

TO THE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any fee is necessary, please enclose it with this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records.

TO THE FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12895 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 12862

1. PLACE OF DEATH a. COUNTY <u>Prince Geo</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Pr Geo</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>Doa</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Geo General</u>				d. STREET ADDRESS <u>6018 Naval Ave</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>FLOYD ALLEN ADAMS</u>				4. DATE OF DEATH Month Day Year <u>Nov 30 1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 26 1911</u>	9. AGE (In years, full birth date) <u>49</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Real Estate</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>LEE W ADAMS</u>				14. MOTHER'S MAIDEN NAME <u>Fannie Adams (Allgood)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>534-899643</u>		17. INFORMANT Address <u>Morie Adams - as above</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>met</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Dayton Watkins</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>DAYTON WATKINS</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>11-30-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12.3.1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>George Washington</u>		22d. LOCATION (City, town, or county) (State) <u>Hyattsville. Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home. 300.4th.st N E.Wash.D</u>				24a. REC'D BY REGISTRAR <u>DEC 2 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

MEDICAL CERTIFICATION

1500 MEDICAL EXAMINERS' OFFICE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

12896
M
077
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B1
12896
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12863

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant 29			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Joseph L. Armstrong				4. DATE OF DEATH Month Day Year November 3, 1960			
5. SEX Male		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 30, 1920	
9. AGE (In years lost birthday) 39 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. BIRTHPLACE (State or foreign country) Washington D C		11. CITIZEN OF WHAT COUNTRY? U S A	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bartender				10b. KIND OF BUSINESS OR INDUSTRY Restaurant			
13. FATHER'S NAME Francis Armstrong				14. MOTHER'S MAIDEN NAME Mary O' Donnell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes				16. SOCIAL SECURITY NO. W W 11 579 14 4086			
17. INFORMANT Mildred A Armstrong				Address Seat Pleasant, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153.9 DUE TO Abdominal carcinoma toxic Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Adeno Ca of large bowel DUE TO (c) ?				INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs ?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Seat Pleasant				20g. (County) Prince Georges		20h. (State) Md.	
21. I certify that (I) (this hospital) attended the deceased from 5-31-60 to 11-3-60 that (I) (we) last saw the deceased alive on 11-2-1960, and that death occurred at 24 M, from the causes and on the date stated above.							
22a. SIGNATURE Jeanne C Bateman				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11-3-60	
22c. PHYSICIAN'S NAME (Type) Jeanne C Bateman				22d. ADDRESS 940-25 St NW, Wash DC			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov 7, 1960		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town, or county) (State) Suitland Md.	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR NOV 9 60	
				25b. REGISTRAR'S SIGNATURE Arthur J. Hinkle			

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
12897 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12864

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>		c. LENGTH OF STAY IN 1b <u>Dead in arrival</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince George's General Hospital</u>				d. STREET ADDRESS <u>14706-68th Place</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Anna</u> First <u>Lon</u> Middle <u>Barnett</u> Last				4. DATE OF DEATH Month <u>Nov</u> Day <u>17</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 26, 1916</u>	
9. AGE (In years last birthday) <u>44</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>		11. BIRTHPLACE (State or foreign country) <u>Tennessee</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.-C</u>							
13. FATHER'S NAME <u>Andrew Dalton King</u>				14. MOTHER'S MAIDEN NAME <u>Carrie Whitten</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u> </u>			
17. INFORMANT <u>Joseph D. Barnett</u>				Address <u>some street</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Coronary arteriosclerosis</u> DUE TO (c) <u>heart disease</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>James I. Boyd</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <u>11-17-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 19, 1960</u>		22c. NAME OF CEMETERY OR CEMETERY <u>George Washington</u>		22d. LOCATION (City, town, or country) (State) <u>Hyattsville, Md.</u>	
23. FUNERAL DIRECTOR <u>F. Gasch's Sons</u>				ADDRESS <u>Hyattsville, Md.</u>			
24a. REC'D BY REGISTRAR <u>NOV 23 '60</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knecht</u>			

UNITED STATES DEPARTMENT OF THE ARMY
OFFICE OF THE CHIEF OF ENGINEERS
WASHINGTON, D. C. 20315

THE ADJUTANT GENERAL
WASHINGTON, D. C. 20315

TO: THE ADJUTANT GENERAL
FROM: THE CHIEF OF ENGINEERS
SUBJECT: [Illegible]

[The body of the letter contains several paragraphs of text that are extremely faint and illegible due to the quality of the scan. It appears to be a formal communication regarding engineering matters.]

Very truly yours,
[Illegible Signature]
[Illegible Title]

cc: [Illegible]
[Illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12986

CERTIFICATE OF DEATH

Reg. Dist. No.

12865

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY PRINCE GEO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MARYLAND PARK		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MARYLAND PARK	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 403-65th ST.		d. STREET ADDRESS 1403-65th ST.	
3. NAME OF DECEASED (Type or print) First Middle Last HANNAH E. BATTERS		4. DATE OF DEATH Month Day Year NOVEMBER 7 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 3, 1878
9. AGE (In years lost birthday) 82 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) NEW JERSEY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS YARROW GARTON		14. MOTHER'S MAIDEN NAME LYDIA MARY SMALLWOOD	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. —	
17. INFORMANT CAROLYN L. GARE Address 403-65th ST. MD. PK. MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA, LEFT BREAST, WITH METASTASES 170X DUE TO (b) CDNAUGHT Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) 5 years INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension, chronic			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 11, 1951 to Nov 7, 1960 , that I last saw the deceased alive on Nov 5, 1960 , and that death occurred at 6:50 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Ernest E. Cornelsen M.D.		ADDRESS (Street, city or town, state) 4400 BOWEN RD SE	
PHYSICIAN'S NAME (Type) ERNEST E. CORNELSEN		DATE SIGNED WASHINGTON 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) 11-10-60		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Union		22d. LOCATION (City, town, or county) (State) Mays Landing NJ	
23. FUNERAL DIRECTOR'S SIGNATURE J. Wm Lee Sons Co ADDRESS 300-4th st N.E		24a. REC'D BY REGISTRAR DATE NOV 9 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 12887 CERTIFICATE OF DEATH

12866

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u>				c. LENGTH OF STAY IN 1b <u>5 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>903 Cox Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Nellie W. Beaver</u>				4. DATE OF DEATH Month Day Year <u>Nov 24 1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 30 1872</u>	
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>INDIANA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>LYMAN R. WILLIAMS</u>				14. MOTHER'S MAIDEN NAME <u>ALMA McCLUNG</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)			
17. INFORMANT Address <u>WAYNE BENEDICT 903 Cox Ave Hyatts Md</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHO PNEUMONIA</u> 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>HYPERTENSIVE CARDIO VASCULAR DISEASE</u> 7 yrs DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>June 1953</u> to <u>Nov 24 1960</u> , that I last saw the deceased alive on <u>Nov 24 1960</u> , and that death occurred at <u>9:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Norman Donat Comenau</u> M.D.				ADDRESS (Street, city or town, state) <u>3503 Penny St 11/24/60</u>			
PHYSICIAN'S NAME (Type) <u>NORMAN DONAT COMENAU</u>				DATE SIGNED <u>MT RAINIER MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>CREMATION</u>		<u>11-26-1960</u>		<u>CEDARHILL CREMATORY</u>		<u>SUITLAND MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Joseph G. Goulet & Sons, Inc. 1756 Pa. Ave NW Wash, D.C.</u>				24a. REC'D BY REGISTRAR <u>NOV 28 60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thompson</u>	

BP

15082

CO. 4. 100 AT 1000

4-100 1000 1000 1000

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please indicate the certificate, writing the word "pending" in pencil in item 18, G. Pages 1, 2, and 3 to the funeral director. Page 3 should be forwarded to the Chief Medical Examiner's Office along with form MM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in no event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
12967 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12867

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Forestville</u> c. LENGTH OF STAY IN 1b <u>3 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give st. or address) <u>5512 - North Forest Edge Road</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Forestville</u> d. STREET ADDRESS <u>5512 - North Forest Edge Road</u>	
3. NAME OF DECEASED (Type or print) <u>Rose Ella Bennett</u> First Middle Last		4. DATE OF DEATH <u>November 22 1960</u> Month Day Year	
5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>Aug 16, 1885</u> yrs. Months Days		9. AGE (In years, last birthday) <u>75</u> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Tucker</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Jane Richardson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Ethel Louise Cooper</u>		Address <u>5375 Auth Rd Wash 23, D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Haemorrhage</u> <u>002X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Bronchiectasis, Bilateral lobar</u> (a), stating the underlying cause last. (c) <u>pneumonia - Pulmonary Tuberculosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter type of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. _____		20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James I. Boyd</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JAMES I. Boyd</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mr 25-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery, Suitland, Md.</u>		22d. LOCATION (City, town, or country) (State)	
23. FUNERAL DIRECTOR <u>Summers Bros 1661 - Gd Hope Rd & 2nd St</u>		24a. REC'D BY REGISTRAR <u>NOV 28 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

22nd Oct



1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. **FUNERAL DIRECTOR:** Pages 3 and 4 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 12898 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12868

1. PLACE OF DEATH a. COUNTY <u>Pr Geo</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN IL <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince Geo General</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>548 WYANDORE AVE</u> IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>EMMA LAVINIA BENSON</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>30</u> Year <u>1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>13 Jan 1870</u> 90 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BALTIMORE, MD</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>GEORGE P. MORRIS</u>		14. MOTHER'S MAIDEN NAME <u>LOUISA WILHELM</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>MR. J. R. BENSON</u>		Address <u>337 GREENLAW BALTIMORE, MD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.0 DUE TO (b) <u>arterial Sclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Generalized arterial sclerosis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1 day</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <u>no</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Dayton O Watkins</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Dayton O Watkins</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/3/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Freeland, Maryland</u>	
23. FUNERAL DIRECTOR <u>Wm. J. Tickner & Sons</u> ADDRESS <u>Balto-17, Md.</u>		24a. REC'D BY REGISTRAR <u>DEC 2 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12950

CERTIFICATE OF DEATH

Reg. Dist. No. 12869

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel				c. LENGTH OF STAY IN 1b Laurel			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Laurel General Hospital				d. STREET ADDRESS 605 Fairlawn Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Frederick Wilson Besley				4. DATE OF DEATH Month Day Year November 8 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 16, 1883	
9. AGE (In years last birthday) 77 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Doctor of Science		10b. KIND OF BUSINESS OR INDUSTRY Virginia		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? Bartholomew Besley				13. FATHER'S NAME Sara Wilson			
14. MOTHER'S MAIDEN NAME Sara Wilson				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO				17. INFORMANT Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO Arteriosclerosis (c)							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 6/6 1954 to 11/8 1960 that I last saw the deceased alive on 11/8 1960 and that death occurred at 11/8 1960 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE John M. Warren, M.D.							
PHYSICIAN'S NAME (Type) John M. Warren, M.D., 305 Prince George Street, Laurel, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 11-10-60		22c. NAME OF CEMETERY OR CREMATORY Green Mount		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons, Inc. 1900 Eutaw Place				24a. REC'D BY REGISTRAR DATE NOV/9 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

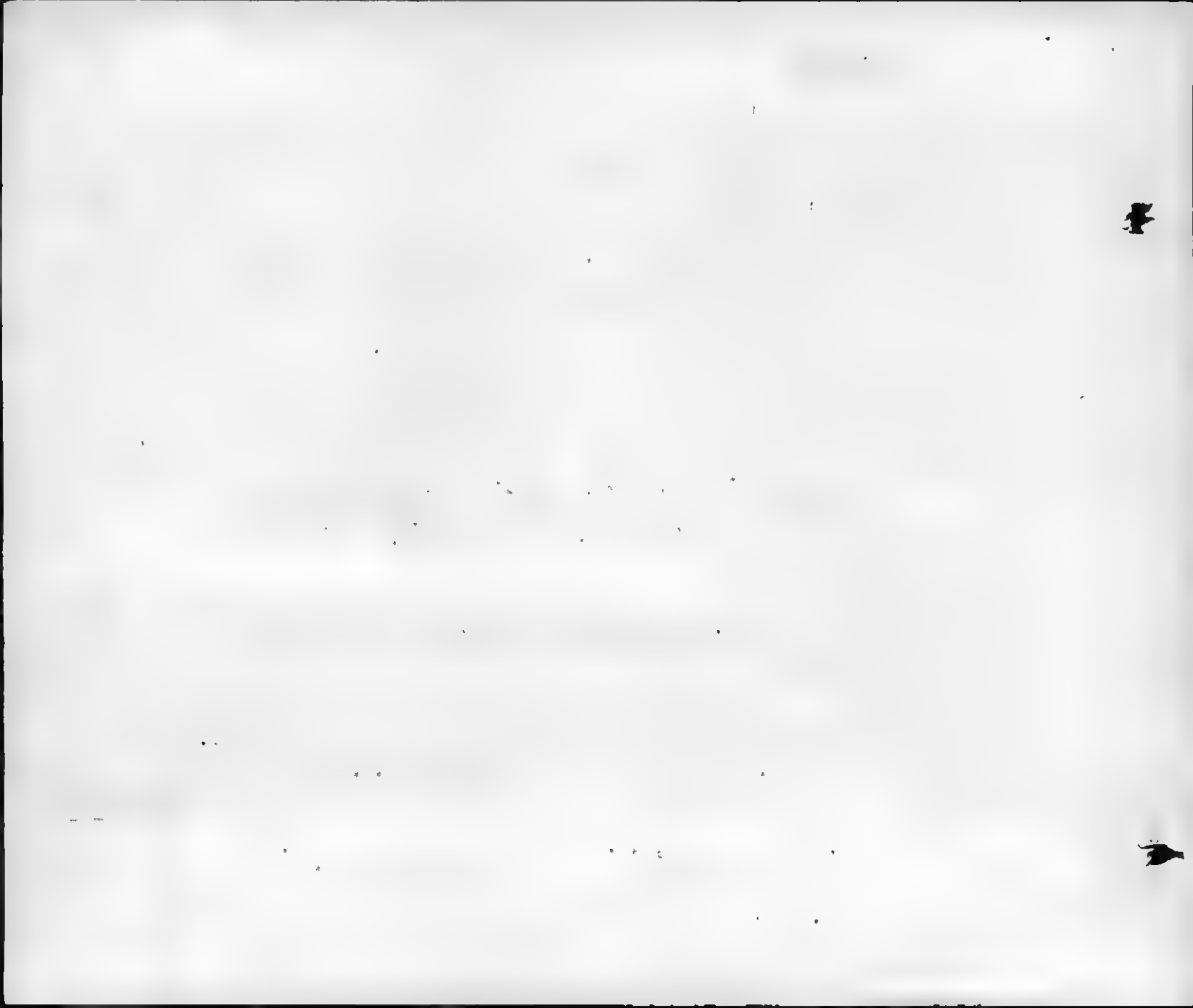
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12899

CERTIFICATE OF DEATH

128970

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 7 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Richard E. Blake		4. DATE OF DEATH Month Day Year November 1 19 60	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 74? yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Md.	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO	
17. INFORMANT Odell Blake		Address Mitchellville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 42. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis HT dis. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of the head of the penis			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11-1-60 to 11-2-60, that (I) (we) last saw the deceased alive on Nov. 1 - 19 60, and that death occurred at 11:40 AM from the causes and on the date stated above.			
22a. SIGNATURE Leonard H. Dietz		22b. DATE SIGNED 11-2-60	
22c. PHYSICIAN'S NAME (Type) Dr. Leonard Dietz, M.D.		22d. ADDRESS 5802 Baltimore Ave., Hyattsville, Md.	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 6, 1960	
23c. NAME OF CEMETERY OR CREMATORY Carroll Church Cemetery		23d. LOCATION (City, town, or county) (State) Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE John T. Stuart		25. REC'D BY REGISTRAR DATE NOV 4 '60	
ADDRESS 3024 St. N.E.		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	



12888

CERTIFICATE OF DEATH

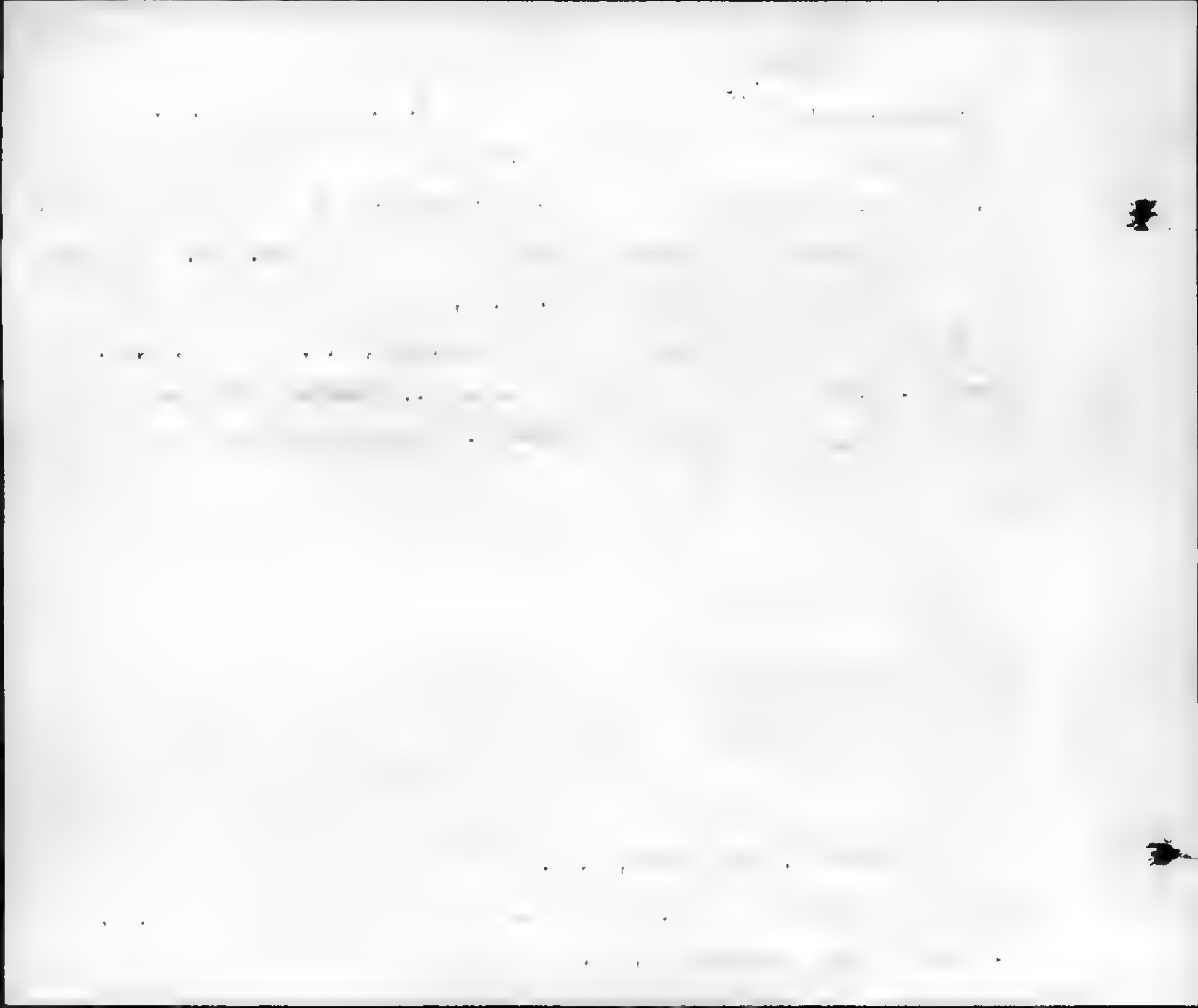
Reg. Dist. No.

12871

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE D. C. b. COUNTY S. E.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville				c. LENGTH OF STAY IN 1b 29 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mrs. Bells Nursing Home				d. STREET ADDRESS 718 Brandywine S t.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First JEFFERY Middle THOMAS Last BLOHM				4. DATE OF DEATH Month Nov. Day 14 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 9, 1960	
9. AGE (In years last birthday) 2 yrs		10. IF UNDER 1 YEAR Months 2 Days 8		11. IF UNDER 24 HRS. Hours 8 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Thomas W. Blohm				14. MOTHER'S MAIDEN NAME Lahni M. Nicholson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None			
INFORMANT Thomas W. Blohm (Father)				Address Same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 754.5 non-cholera DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Congenital Heart Disease - Multiple Defects DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 10/14/60 10/14/60							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 10/15 , 19 60 , to 11/14 , 19 60 , that I last saw the deceased alive on 11/14 , 19 60 , and that death occurred on 11/14 M, from the causes and on the date stated above ADDRESS (Street, city or town, state) 6905 Rock 2nd St DATE SIGNED ACTUAL SIGNATURE Thomas A. Christensen M.D. Carolee Park, Maryland PHYSICIAN'S NAME (Type) Thomas A. Christensen, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/15/60		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE NOV 16 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline							

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



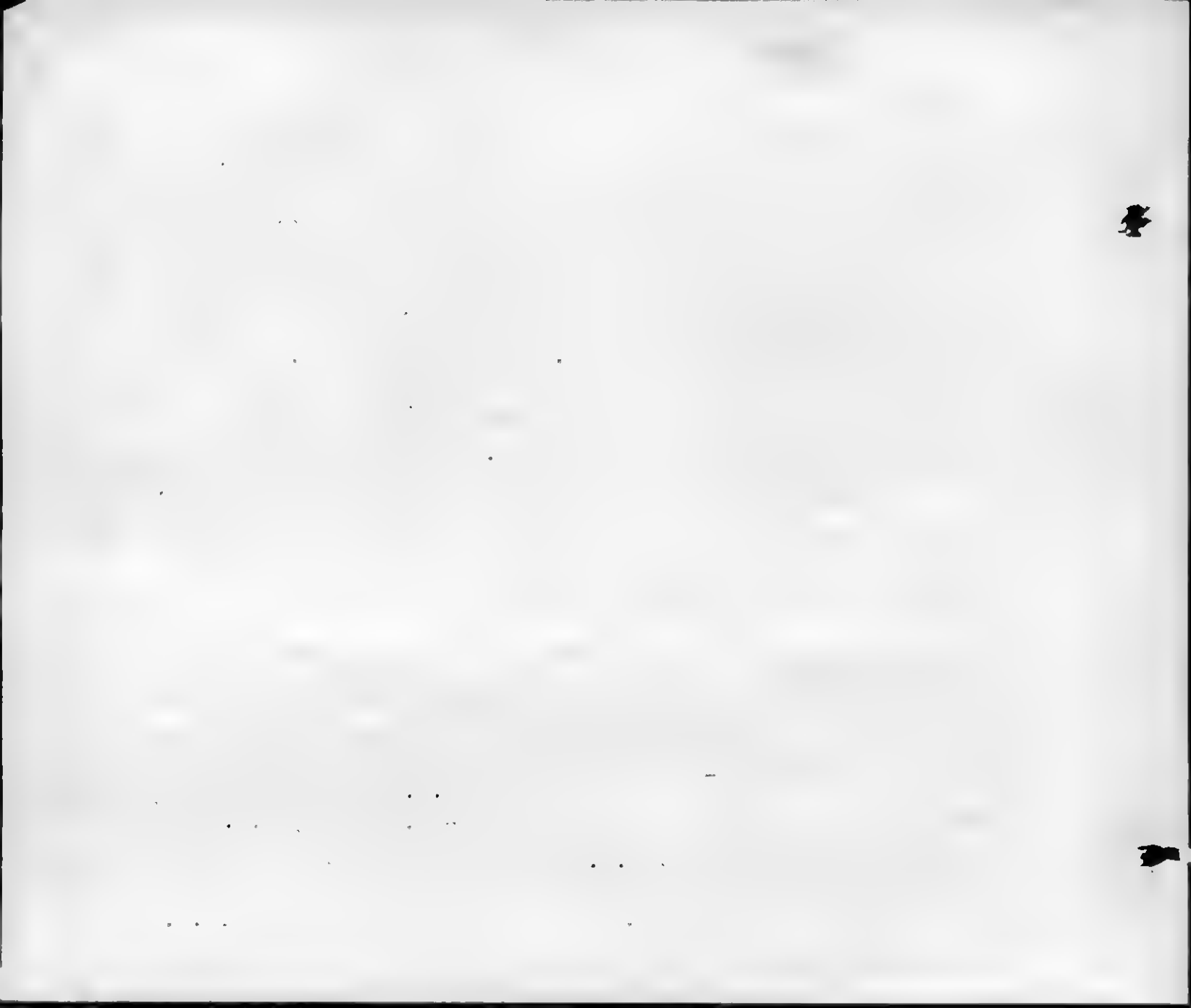
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12968
CERTIFICATE OF DEATH

12872

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillcrest Heights		c. LENGTH OF STAY IN 1b 10 years		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillcrest Heights	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2902 Fairlawn Street, SE			d. STREET ADDRESS 2902 Fairlawn St., SE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last BERNARD LEO BORGER			4. DATE OF DEATH Month Day Year November 15, 1960		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 24, 1889		9. AGE (In years last birthday) 71 yrs
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Plate Printer - US Gov't.		10b. KIND OF BUSINESS OR INDUSTRY Washington, D.C.		11. BIRTHPLACE (State or foreign country) USA	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME John Henry Borger		
14. MOTHER'S MAIDEN NAME Appolonia Nau			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) [If yes, give war or dates of service] No		
16. SOCIAL SECURITY NO No			17. INFORMANT Ida M. Borger #2 above		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Glomerulonephritis DUE TO (c) Arteriosclerotic Heart Disease					INTERVAL BETWEEN ONSET AND DEATH 3 weeks 2 years 5 years
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 322- H. Street, N.E.	
20f. (City or town) Washington 2, D.C.		20g. (County) Washington, D.C.		20h. (State) Washington, D.C.	
21. I certify that I attended the deceased from 4/28/1947 19__ to 11/15/1960 19__, that I last saw the deceased alive on 11/11/1960 19__, and that death occurred at 12:30 M, from the causes and on the date stated above. P. M. ADDRESS (Street, city or town, state) 322- H. Street, N.E. Washington 2, D.C.					
ACTUAL SIGNATURE <i>Thomas F. Collins</i>		M.D. Thomas F. Collins, M.D.		DATE SIGNED 11/15/1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-18-60		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	
22d. LOCATION (City, town, or county) Washington, D.C.		22e. (State) Washington, D.C.		22f. (Country) USA	
23. FUNERAL DIRECTOR'S SIGNATURE James T. Ryan, Inc.		ADDRESS 317 Pa. Ave., SE		24a. REC'D BY REGISTRAR NOV 18 '60	
24b. REGISTRAR'S SIGNATURE <i>Wm. L. Thomas</i>		24c. REGISTRAR'S SIGNATURE <i>Wm. L. Thomas</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





12951

CERTIFICATE OF DEATH

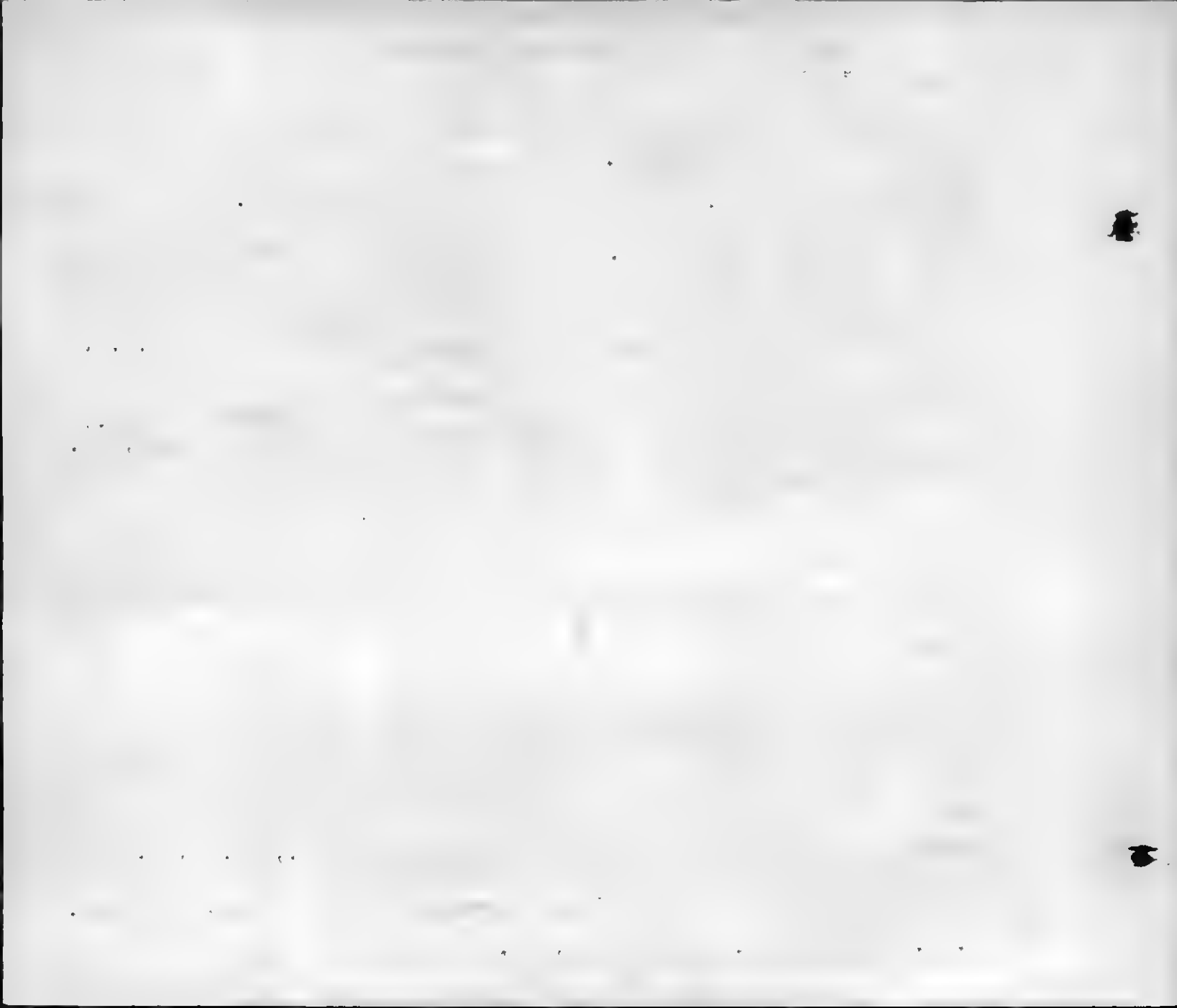
12874

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel				c. LENGTH OF STAY IN 1b 60 Mrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) 1425 Sandy Spring Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Catherine Middle R. Last BRANZELL				4. DATE OF DEATH Month Nov Day 26 Year 19 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12 Oct 1888	
9. AGE (in years last birthday) yrs. 72		IF UNDER 1 YEAR Months 2 Days 2 Hours 0 Min 0		IF UNDER 24 HRS Months 0 Days 0 Hours 0 Min 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Washington, D/C/	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) No N/A				16. SOCIAL SECURITY NO None		17. INFORMANT John F Branzell 4206 Newark Rd., Colmar Manor, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 442X respiratory tract change DUE TO acute leukemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — DUE TO — (c) —							INTERVAL BETWEEN ONSET AND DEATH 2 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY: Month, Day, Year Hour 6 a.m. 19 p. m.				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	
20f. (City or town) —				20g. (County) —		20h. (State) —	
21. I certify that I attended the deceased from 11/20 , 19 60 , to 11/26 , 19 60 , that I last saw the deceased alive on 11/25 , 19 60 , and that death occurred at 11 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 314 Compton Ave., Laurel, Md. DATE SIGNED 11/26/60							
ACTUAL SIGNATURE N B Stewart				M.D. 314 Compton Ave., Laurel, Md.			
PHYSICIAN'S NAME (Type) N B STEWARD				314 Compton Ave., Laurel, Md. 11/26/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/30/60		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Bladensburg, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. CHAMBERS CO.,				ADDRESS Riverdale, Md.		24a. REC'D BY REGISTRAR DATE NOV 29 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Brown			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL: The low requires that the death certificate be submitted within 24 hours after death. Pages 1 and 2 should be filled in by the funeral director or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

12901

STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12875

1. PLACE OF DEATH a. COUNTY Prince Georges				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN lb 4 d aym			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				d. STREET ADDRESS 4102 Crittenden Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Hohn		First C Middle Brooke Last Sr.		4. DATE OF DEATH Month Nov Day 13 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 17 Feb 1881	
9. AGE (In years lost birthday) 79 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Jaquelin Ambler Brooke				14. MOTHER'S MAIDEN NAME Elizabeth Bruce Green			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO (If yes, give war or dates of service)		17. INFORMANT Alice L. Brooke (Wife) Same as No. 2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 36 hrs 5 yrs.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 19 57 to Mar 13 19 60 , that (I) (we) last saw the deceased alive on Mar 13 19 60 , and that death occurred at 6:05A from the causes and on the date stated above.							
22a. SIGNATURE Norman Donald Comeau		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11/13/60			
22c. PHYSICIAN'S NAME (Type) Dr. Norman Comeau M.D.		22d. ADDRESS 3508 Perry St. Mt. Rainier, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/15/60		23c. NAME OF CEMETERY OR CREMATORY George Washington		23d. LOCATION (City, town, or county) (State) Hyattsville Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Arthur L. Kraus				25a. REC'D BY REGISTRAR DATE NOV 16 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1290 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

12876

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upper Marlboro</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Carrie</u> Middle <u>Isabelle</u> Last <u>Brooks</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>11</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-11-92</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>John Simms</u>				14. MOTHER'S MAIDEN NAME <u>Susie Savy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>442X</u> <u>cerebral thrombosis</u>							
DUE TO (b) <u>Cardiovascular disease</u>							
DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James I. Boyle</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JAMES I. BOYLE</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Nov 11, 1960</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-14-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Union Methodist Church</u>		22d. LOCATION (City, town, or county) (State) <u>Upper Marlboro, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William F. Funch</u>				24a. REC'D BY REGISTRAR <u>NOV 14 60</u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

MEDICAL CERTIFICATION



12969

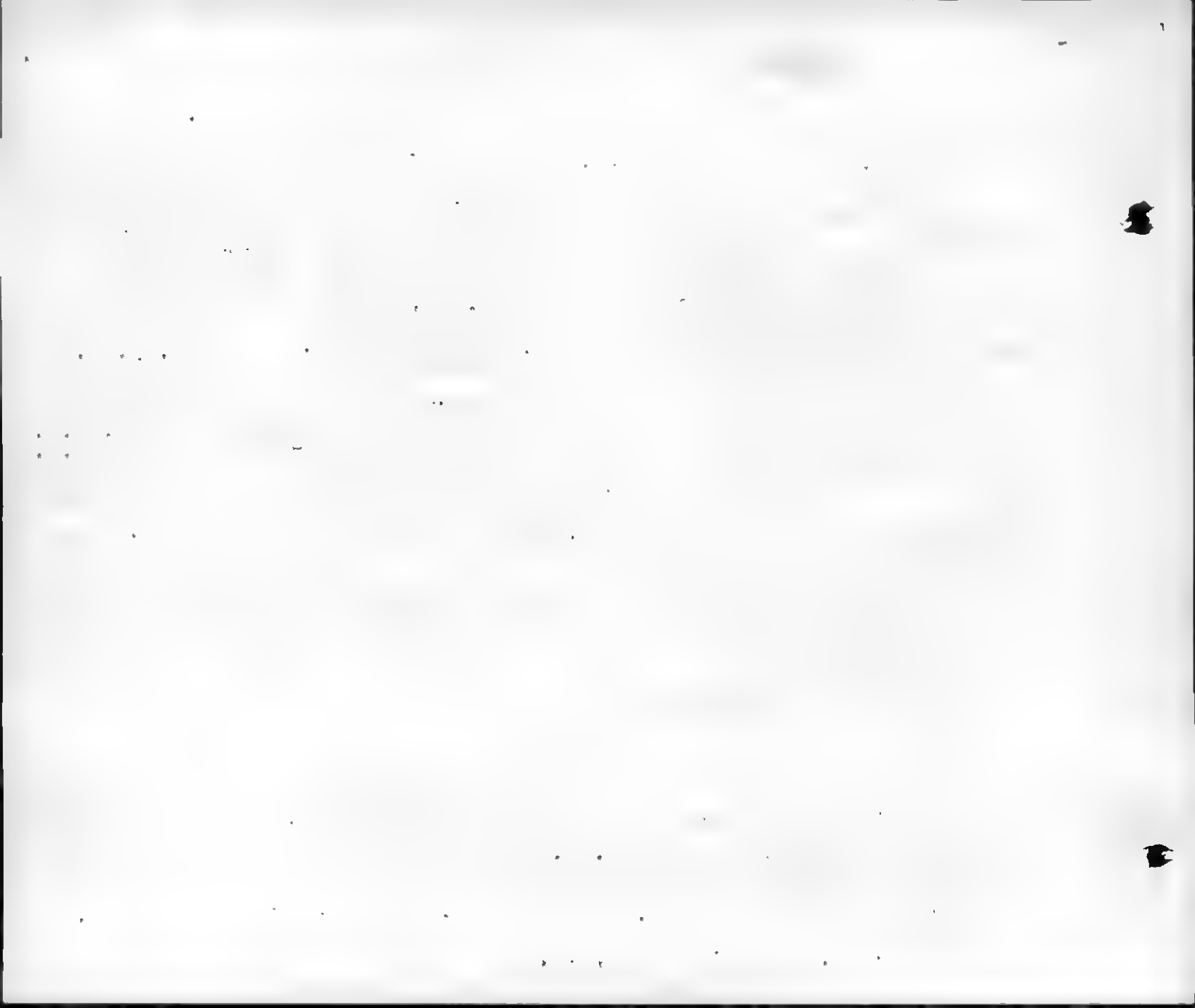
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges' MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Main Street		d. STREET ADDRESS Main Street	
3. NAME OF DECEASED (Type or print) First William Middle R Last Buck		4. DATE OF DEATH November 19, 1960	
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 14, 1877
9 AGE (In years last birthday) 83 yrs		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Service Station Oper.		10b. KIND OF BUSINESS OR INDUSTRY Own Business	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Daniel Buck		14. MOTHER'S MAIDEN NAME Susan Robinson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ---	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO (b) Arteriosclerotic CV Disease DUE TO (c) 10 yrs		INTERVAL BETWEEN ONSET AND DEATH 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
18a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		18b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
19a. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		19b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20b. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 1959 to 19 Nov 1960 , that I last saw the deceased alive on 18 Nov 1960 , and that death occurred at 3:04 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE R. B. Sasscer		M.D. Upper Marlboro, Md. DATE 11/19/60	
PHYSICIAN'S NAME (Type) Robert B. Sasscer, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/22/60	22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery	22d. LOCATION (City, town, or county) (State) Upper Marlboro, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros.-Upper Marlboro, Md.		24a. REC'D BY REGISTRAR DATE NOV 28 '60	
24b. REGISTRAR'S SIGNATURE Charles E. Hines			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 after death. Page 2 after death. Page 3 after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



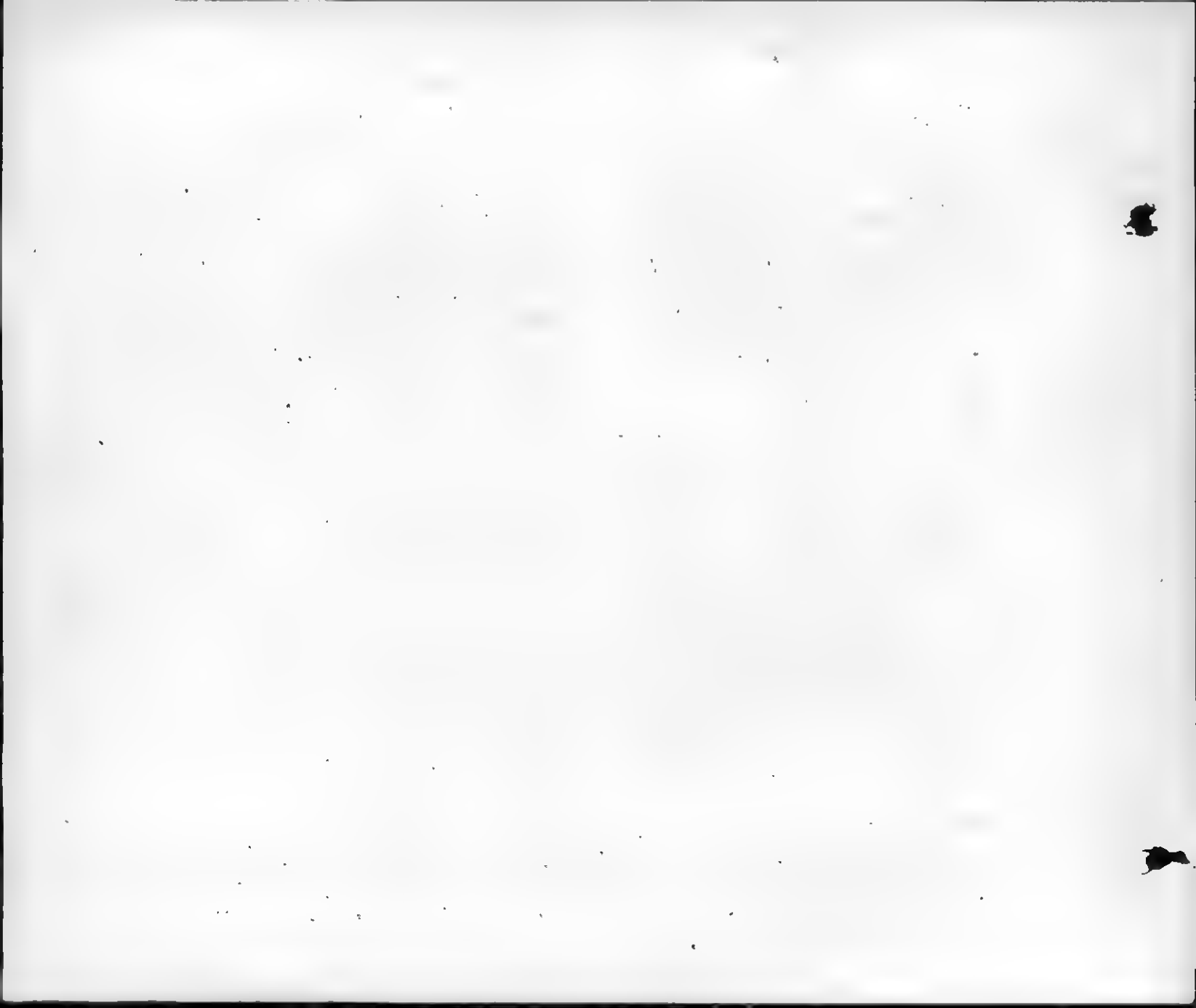
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12889 CERTIFICATE OF DEATH

Reg. Dist. No. **12878**

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> c. LENGTH OF STAY IN 1b <u>3 years</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Carroll County, Md. 49221</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Washington</u> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) _____ d. STREET ADDRESS <u>2924 Naylor Rd. S.E.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Mrs. Clara</u> First <u>H</u> Middle <u>E</u> Last <u>Living</u> 4. DATE OF DEATH <u>November 18</u> 19 <u>60</u>			5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>5/23/80</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years, lost birthday) <u>80</u> yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse (undergrad)</u> 10b. KIND OF BUSINESS OR INDUSTRY _____ 11. BIRTHPLACE (State or foreign country) <u>Charleston, W. Va.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>James H. Martin</u> 14. MOTHER'S MAIDEN NAME <u>Elizabeth Marie</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) _____ 16. SOCIAL SECURITY NO <u>544-48-4118</u> INFORMANT <u>David L. Leach</u> Address _____ 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia - Congestive Heart Failure</u> (b) <u>ASPD and Metastatic CA</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____ 20c. TIME OF INJURY Month, Day, Year _____ Hour o. m. _____ p. m. _____ 19____ 20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21. I certify that I attended the deceased from <u>5</u> , 19 <u>54</u> , to <u>11/18</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>11/18</u> , 19 <u>60</u> , and that death occurred at <u>8:30 PM</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <u>David L. Leach</u> M.D. <u>2401 Fairview St SE 11/18/60</u> ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ PHYSICIAN'S NAME (Type) <u>David L. Leach</u> <u>H. Hunt Hospital</u>							
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>Nov. 22, 1960</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u> 22d. LOCATION (City, town, or county) <u>Montgomery County, Md.</u> (State) _____		23. FUNERAL DIRECTOR'S SIGNATURE <u>John W. Miller</u> ADDRESS <u>254 Carroll St NW, DC</u> 24. REC'D BY REGISTRAR <u>Nov 21 '60</u> 24b. REGISTRAR'S SIGNATURE <u>William E. Fennell</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

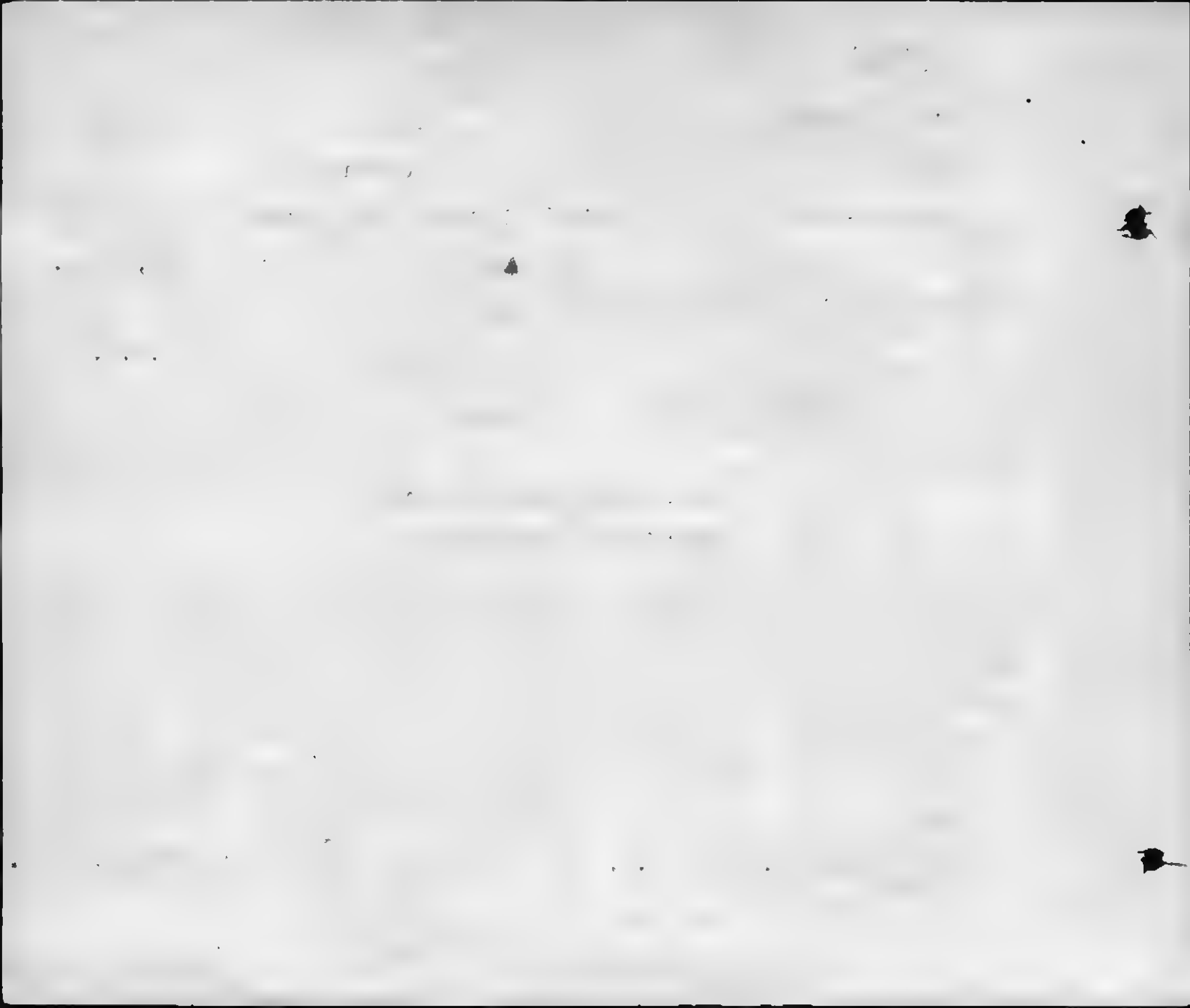
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

12903 12879 MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND **MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Items 7, 8, 9, 11, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
12904 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution, Residence before admission) a. STATE <u>DC</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hospital</u>		d. STREET ADDRESS <u>1133 - 5th St NW</u>	
3. NAME OF DECEASED (Type or print) <u>Bessie Mae Carter</u>		4. DATE OF DEATH <u>Nov 10 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-15-31</u>
9. AGE (In years last birthday) <u>29</u> yrs.		10. UNDER 1 YEAR <u>25</u> Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done, during most of working life, even if retired) <u>Housewife</u>		12. KIND OF BUSINESS OR INDUSTRY <u>South Carolina</u>	
13. BIRTHPLACE (State or foreign country) <u>South Carolina</u>		14. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
15. FATHER'S NAME <u>Bryant Bell</u>		16. MOTHER'S MAIDEN NAME <u>Ardell Sowell</u>	
17. WAS DECEASED IN U.S. ARMY OR U.S. NAVY (Yes, no, or unknown) (If yes give year or dates of service) <u>no</u>		18. SOCIAL SECURITY NO. <u>same as mother</u>	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage and shock</u> 781X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Gun shot wound of abdomen</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c).		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>shot during an altercation</u>	
20c. TIME OF INJURY Month, Day, Year <u>5:00 a.m. 11/10/60</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Washington</u> (County) <u>D.C.</u> (State) <u>DC</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James I. Boyd</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type or print) <u>JAMES I. BOYD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11-20-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>York Rd Cemetery</u>		22d. LOCATION (City, town, or country) <u>Charlotte, N.C.</u> (State) <u>N.C.</u>	
23. FUNERAL DIRECTOR <u>R. L. rough</u> ADDRESS <u>51 Kay St. N.W.</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Kims</u>	
24b. REGISTRAR'S SIGNATURE		DATE NOV 21 '60	



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A ME
7/5

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
12970 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12801

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND										2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillcrest Heights 10 years</u>										c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillcrest Heights</u>											
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2513 Gauthier Street</u>										d. STREET ADDRESS <u>12513 Gauthier Street</u>											
3. NAME OF DECEASED (Type or print) <u>Elizabeth Florence Casey</u>										4. DATE OF DEATH <u>Nov 17 1960</u>											
5. SEX <u>Female</u>										6. COLOR OR RACE <u>White</u>											
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>Aug 14 1923</u>										9. AGE (In years last birthday) <u>37</u> yrs											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>										10b. KIND OF BUSINESS OR INDUSTRY <u>Teaching</u>											
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>										12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>											
13. FATHER'S NAME <u>William Joseph Casey</u>										14. MOTHER'S MAIDEN NAME <u>Emma F. Coffield</u>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>										16. SOCIAL SECURITY NO. <u>578-22-0415</u>											
17. INFORMANT <u>Beth Antkowiak</u>										Address											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> 11-37-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive heart failure</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. <u>Extensive osteoarthritis</u>																				INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19										20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)										20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																					
ACTUAL SIGNATURE <u>James I. Boyd</u> M.D.										CHIEF MEDICAL EXAMINER <input type="checkbox"/>											
EXAMINER'S NAME (Type) <u>James I. Boyd</u>										ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>										22b. DATE THEREOF <u>Nov 19-60</u>											
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>										22d. LOCATION (City, town, or country) (State) <u>Smithland Md</u>											
23. FUNERAL DIRECTOR <u>Sammons Bros</u>										ADDRESS <u>1461 - gd Hope Rd</u>											
24a. REC'D BY REGISTRAR <u>Nov 21 '60</u>										24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>											



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12905 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 12882

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seat Pleasant</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Pr. Geo</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seat Pleasant</u> d. STREET ADDRESS <u>7252 Central Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Walter</u> First <u>Waldo</u> Middle <u>Washington</u> Last <u>COLLINS</u>		4. DATE OF DEATH Month <u>November</u> Day <u>29</u> Year <u>19 60</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12 Feb 1872</u>
9. AGE (In years last birthday) <u>88</u> yrs	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>
10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John Wesley Collins</u>	
14. MOTHER'S MAIDEN NAME <u>Mary E. Hurtle</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>579-28-6321</u>		17. INFORMANT <u>Mrs Ethel Brown (Dau) Same as # 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>420-1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio Sclerosis Heart disease</u> DUE TO <u>Generalized Arterio Sclerosis</u> (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH <u>No</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Notural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Dayton O Watkins</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>DAYTON O WATKINS</u>		<u>11-29-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-2-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Addison's Chapel</u>	22d. LOCATION (City, town, or county) (State) <u>Seat Pleasant, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home - Washington, D.C.</u>		24a. REC'D BY REGISTRAR <u>DEC 1 '60</u>	24b. REGISTRAR'S SIGNATURE <u> </u>

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



1
FOR STATE
HEALTH DEPT.

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TO FUNERAL DIRECTOR: Page 3 should be used as a burial-permit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

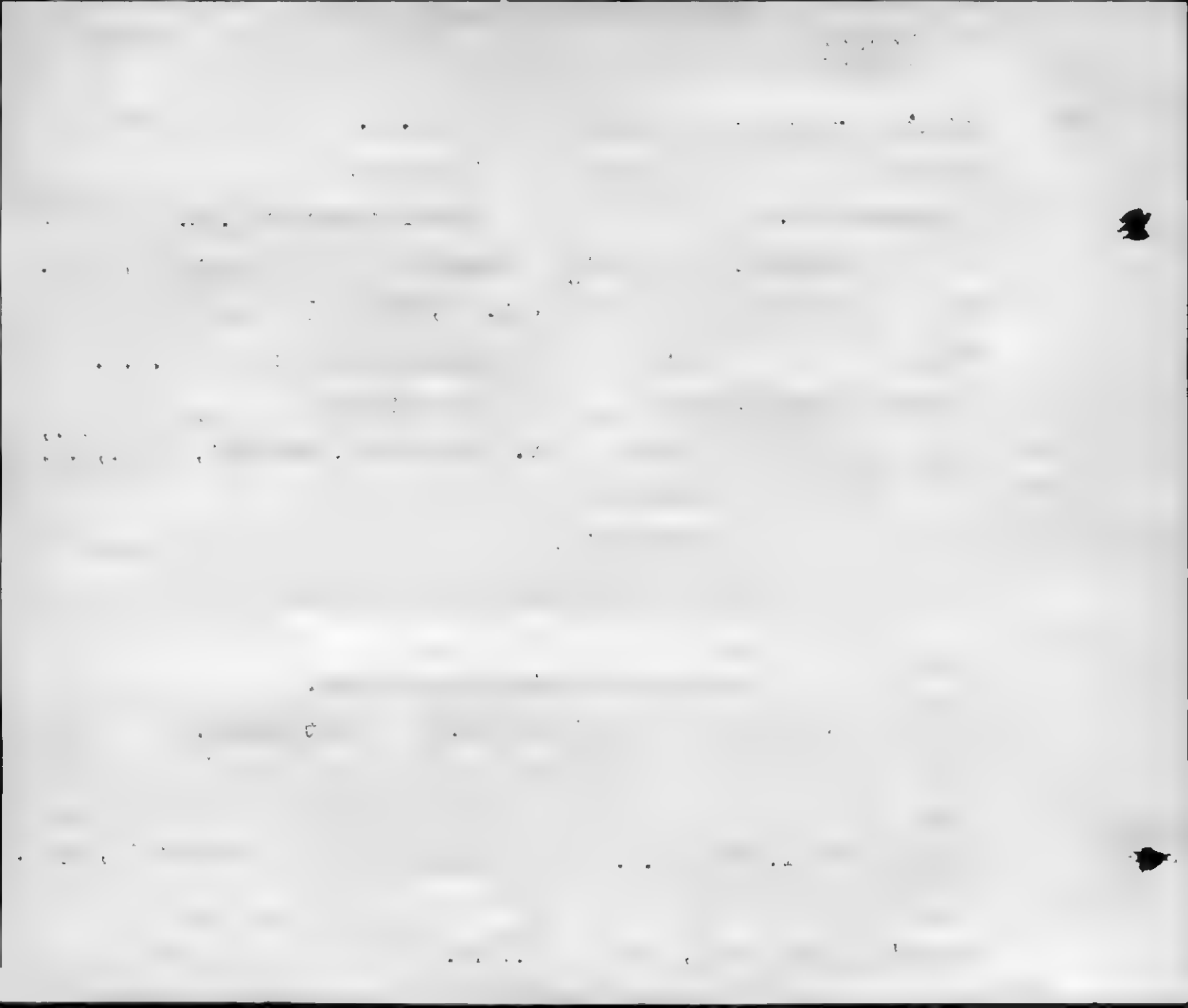
VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
12971 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12883

1. PLACE OF DEATH a. COUNTY Prince Georges County		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ardmore		c. LENGTH OF STAY IN b. Found		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE D. C.		b. COUNTY None		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		d. STREET ADDRESS 2415 14th Street N. E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MICHAEL JOSEPH CONDETTI		4. DATE OF DEATH November 17, 1960.		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 10, 1953		9. AGE (In years last birthday) 7 yrs. 10 months 7 days		10. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY School		11. BIRTHPLACE (State or foreign country) Montgomery County		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Augustine Joseph Condetti		14. MOTHER'S MAIDEN NAME Joan Smithers		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None			
17. INFORMANT Mr. Augustine J. Condetti, Wash., D.C.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. Suffocation DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, a) Seduced and Criminally Assaulted.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18) Seduced and Criminally Assaulted.		20c. TIME OF INJURY Month, Day, Year ? 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Undetermined		20f. (City or town) (County) (State) Undetermined	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED November 18, 1960.		ACTUAL SIGNATURE James I. Boyd		EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/14/60	
23. FUNERAL DIRECTOR NALLEY'S FUNERAL HOME, Island Ave. N.E.		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or country) (State) Arlington, Va.		24a. REC'D BY REG. STRAR NOV 28 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Harris		24c. ADDRESS (Street, city, town, or county) 3200 Rhode		24d. DATE NOV 28 '60		24e. SIGNATURE Arthur S. Harris			

Mt. Rainier Md



may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4

12972

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12884

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE DC b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland		c. LENGTH OF STAY IN 1b 6 Weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suitland Nursing Home		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.	
3. NAME OF DECEASED (Type or print) First Middle Last FRANK DATTORE		4. DATE OF DEATH Month Day or Nov. 7th 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 3rd. 1883
9. AGE (In years last birthday) 77 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Iron Worker	
11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Borsilo Dattore		14. MOTHER'S MAIDEN NAME Rosina Unk.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 17. INFORMANT 5951- 28th Ave., S.E. Frank V. Dattore Marlow Heights, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH? 2 weeks 15 years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 10, 1960, to Nov 6, 1960, that (I) (we) last saw the deceased alive on 11-6-1960, and that death occurred at 7:00 AM, from the causes and on the date stated above			
22a. SIGNATURE Thomas F. Cleary		22b. ADDRESS 5556 Silver Hill Rd. SE District Heights Md.	
22c. PHYSICIAN'S NAME (Type) Dr. Thomas F. Cleary		22d. ADDRESS 5556 Silver Hill Rd. SE District Heights Md.	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 9 -1960	
23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		23d. LOCATION (City, town, or county) (State) Washington, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE Annora Bros.		25a. REC'D BY REGISTRAR DATE NOV 8 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Harris			

(M)

1010

(I)



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 12880

12906

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN lb D. O. A. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Bowie d. STREET ADDRESS 231 9th Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Florence First Annie Middle Florence Last Day		4. DATE OF DEATH Nov. Month 22, Day 19 Year 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 13, 1892
9. AGE (in years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Warren Phelps		14. MOTHER'S MAIDEN NAME Capitola Johnson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Ellis Cross Day	
17. INFORMANT 1006 Maple Ave. Bowie, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart failure DUE TO (b) Arteriosclerotic heart disease DUE TO (c) 2 1/2 years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis Generalized 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. no		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. 19 Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Dayton O Watkins M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) DAYTON O WATKINS		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/25/60	
22c. NAME OF CEMETERY OR CREMATORY Holy Trinity		22d. LOCATION (City, town, or county) (State) Collington Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.	
24a. REC'D BY REGISTRAR NOV 28 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 48 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

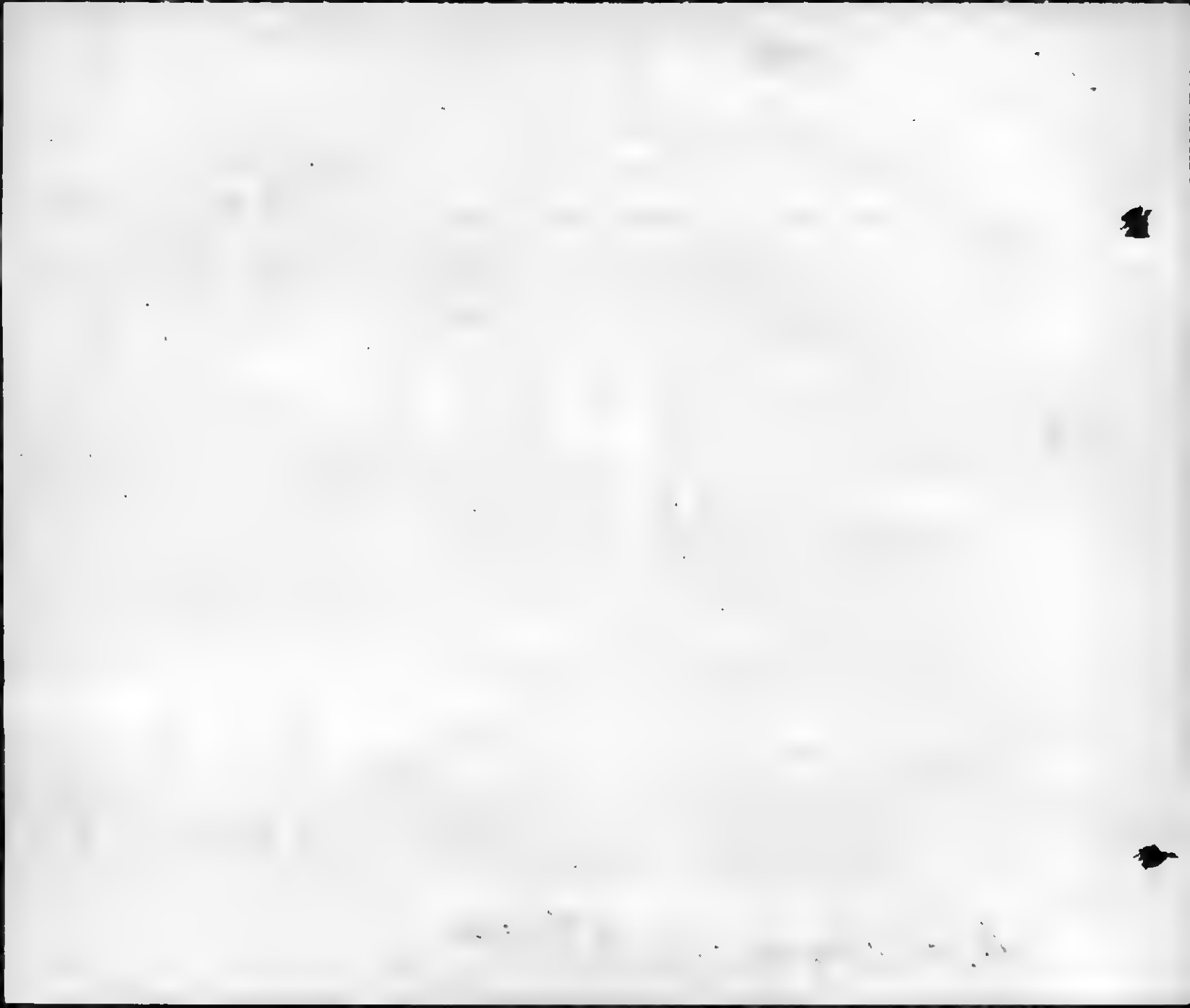
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12890

12886

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		c. LENGTH OF STAY IN 1b <u>2 yrs 10 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Carroll Manor</u>				d. STREET ADDRESS <u>4922 La Salle St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>NELLE</u> Middle <u>S.</u> Last <u>DEAN</u>				4. DATE OF DEATH Month <u>11</u> Day <u>25</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Wk</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/22/88</u>	9. AGE (In years last birthday) <u>72</u> yrs	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>		IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles W. Shiles</u>				14. MOTHER'S MAIDEN NAME <u>Sally</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown. If yes, give war or dates of service.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Jane Dean</u> Address <u>223 W. Montgomery St. Rockville, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO <u>Cerebrovascular Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u> </u>						3 days 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>No</u>				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>				20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>1954</u> to <u>11/25</u> 19 <u>60</u> that (I) (the) last saw the deceased alive on <u>11/25</u> 19 <u>60</u> and that death occurred at <u>8 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Adolph H. Friedman</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11/25/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>ADOLPH H. FRIEDMAN</u>				22d. ADDRESS <u>900-17th St. NW Wash. D.C.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/28/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greenhill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Berryville, Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		25a. REC'D BY REG. STRAR DATE <u>NOV 29 '60</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12907 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

12887

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Pr Geo</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>1 hour</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Geo General</u>				d. STREET ADDRESS <u>3908-53 PL 1</u>			
3. NAME OF DECEASED (Type or print) First <u>SUSAN B</u> Middle <u>DE ROOY</u> Last <u></u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>8</u> Year <u>1960</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 25 1989</u> yrs. <u>71</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		11. IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>James Edward Foxcott</u>				14. MOTHER'S M maiden name <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u></u>			
17. INFORMANT <u>Barbara Foxcott</u>				Address <u>allison St London Heights</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>arteriosclerotic Heart</u> (c) <u>disease</u> DUE TO cause lost. (c) <u>disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>about 1 hour</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/> <u>no</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>			
20c. TIME OF INJURY Hour <u></u> a. m. <u></u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
22. ACTUAL SIGNATURE <u>Dayton O. Watkins</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>DAYTON O. WATKINS</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/14/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley's Funeral Home</u>				ADDRESS <u>3260-R, J. Ave Mt. Rainier, Md.</u>		24. REC'D BY REGISTRAR <u></u> DATE <u>NOV 14 '60</u>	
25. REGISTRAR'S SIGNATURE <u></u>				26. REGISTRAR'S SIGNATURE <u></u>			

MEDICAL CERTIFICATION

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.



CERTIFICATE OF DEATH

Reg. Dist. No. 12888

12908

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Pr Geo</i> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cheverly</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cheverly</i> 4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Prince Georges General</i>		d. STREET ADDRESS <i>2812 Laurel ave</i>	
3. NAME OF DECEASED (Type or print) <i>Urban</i> First <i>J</i> Middle <i>Dowling</i> Last		4. DATE OF DEATH Month <i>11</i> Day <i>26</i> Year <i>1960</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 12, 1912</i>
9. AGE (In years last birthday) <i>48</i> yrs		10. IF UNDER 1 YEAR: Months <i>4</i> Days <i>26</i> Hours <i>11</i> Min <i>26</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Physician</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Physician</i>	
11. BIRTHPLACE (State or foreign country) <i>Iowa</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>James Dowling</i>		14. MOTHER'S MAIDEN NAME <i>? Hertel</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>Leona Dowling</i> Address <i>Cheverly Md.</i>	
18. CAUSE OF DEATH [Enter only one cause on line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> 4 hours DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <i>4 hours</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <i>Nov 26, 1960</i> , to <i>Nov 26, 1960</i> that I last saw the deceased alive on <i>Nov 26, 1960</i> and that death occurred at <i>1:50 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Dayton Watkins</i>		ADDRESS (Street, city or town, state) <i>5304 Annapolis Rd</i> DATE SIGNED <i>11-27-60</i>	
PHYSICIAN'S NAME (Type) <i>DAYTON O WATKINS</i>		<i>Bladensburg Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Nov 28, 1960</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Rockville, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>F. Gasch's Sons</i> ADDRESS <i>Hyattsville, Md.</i>		24a. REC'D BY REGISTRAR <i>NOV 29 '60</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur L. Thomas</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be relied by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These pages remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

12956

1288.

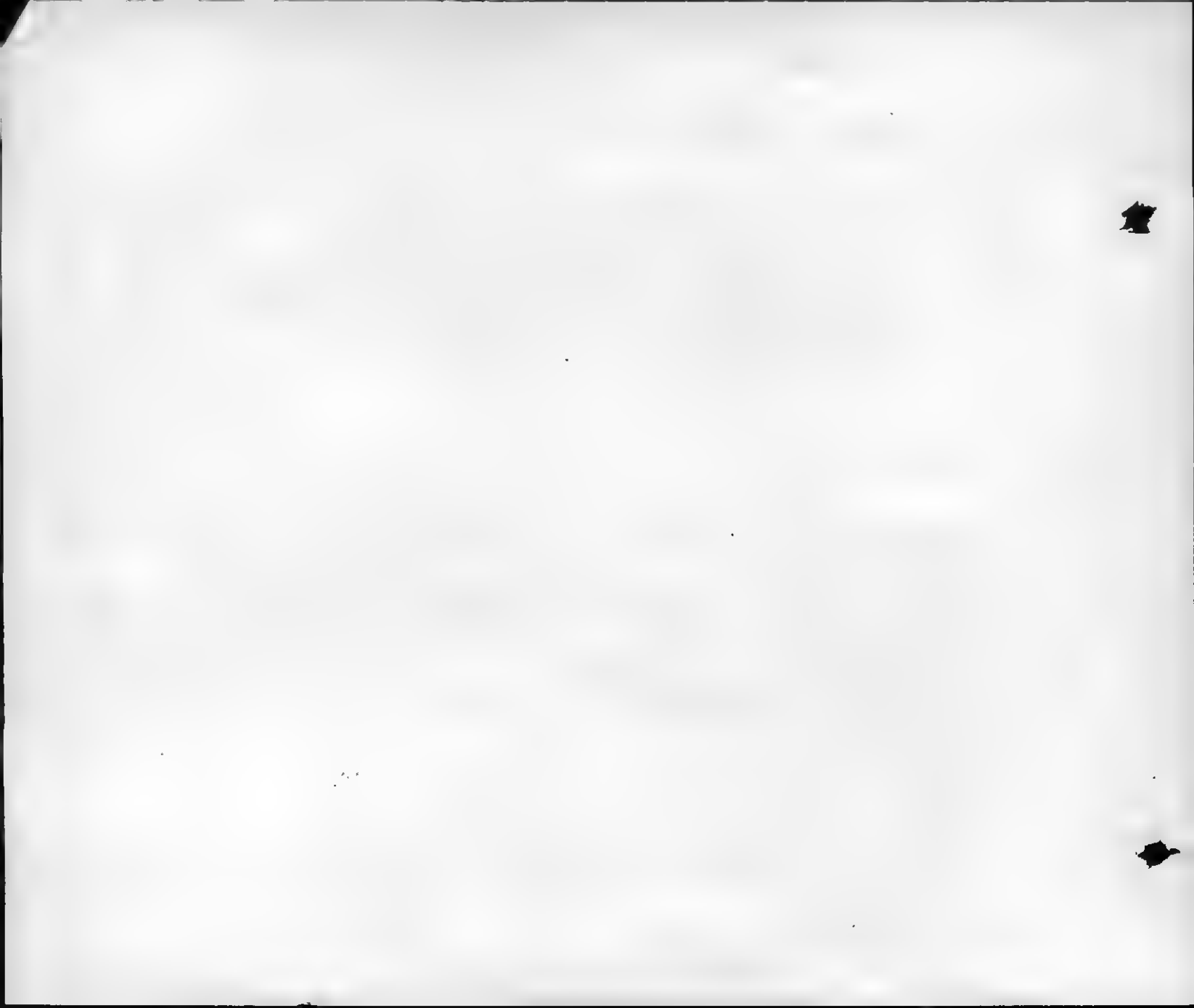
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Leland Mem. Hospital		d. STREET ADDRESS: 112030 Gunpowder Rd	
3 DECEASED (Type or print) First Middle Last Mary Ellen Dunagin		4. DATE OF DEATH Month Day Year Nov. 25 1960	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 3/1/78
9 AGE (In years last birthday) 82 yrs		10 UNDER 1 YEAR Months Days Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b KIND OF BUSINESS OR INDUSTRY ✓	
11 BIRTHPLACE (State or foreign country) S. Carolina		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Russell Gossett		14 MOTHER'S MAIDEN NAME Jane Kirby Gossett	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16 SOCIAL SECURITY NO. None	
17 INFORMANT Daughter		Address Same as	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Cerebral Thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arterio Sclerosis DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 3 days
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) No INJURY	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from Jan. 1960 to Nov. 25, 1960, that (I) (we) last saw the deceased alive on Nov. 25, 1960, and that death occurred at 12:30 PM, from the causes and on the date stated above.			
22a. SIGNATURE R. H. Sandstrom M.D.		22b. DATE SIGNED 11-25-60	
22c PHYSICIAN'S NAME (Type) R. H. Sandstrom M.D.		22d ADDRESS 10202 Lariston Lane, Silver	
23a. BURIAL CREMATION, REMOVAL (Specify)	23b. DATE THEREOF Nov. 28, 1960	23c. NAME OF CEMETERY OR CREMATORY Greenlawn Memorial Garden	23d. LOCATION (City, town, or county) (State) SPARTANBURG N. CAR.
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 254 Carroll St NW D.C.		25a. RECEIVED BY REGISTRAR DATE Nov 28 1960	25b. REGISTRAR'S SIGNATURE Arthur S. Hume

(M)

C/

I



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12947
CERTIFICATE OF DEATH

Reg. Dist. No. 12850

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edmonston		c. LENGTH OF STAY IN 1b Edmonston, Maryland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4816 48th Ave.		d. STREET ADDRESS 4816 48th Ave.	
3. NAME OF DECEASED (Type or print) First Alice Middle Bell Last Dunn		4. DATE OF DEATH Month November Day 18 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 22, 1889
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Clatterbuck		14. MOTHER'S MAIDEN NAME Sarah ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Benjamin F. Dunn 4816 48 Ave.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cute Coronary Thrombosis. 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 19 Month, Day, Year p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9-26- 19 60 to 11-18- 19 60 that I last saw the deceased alive on 10-31- 19 60 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4314 GALLATIN ST. HYATTSVILLE, MD. DATE SIGNED 11/18/60			
ACTUAL SIGNATURE [Signature]		M.D. 4314 GALLATIN ST. HYATTSVILLE, MD.	
PHYSICIAN'S NAME (Type) Dr. Aaron Deitz, M. D.		HYATTSVILLE, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/21/60	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		22d. LOCATION (City, town, or county) (State) Bladensburg, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. CHAMBERS CO.,		ADDRESS Riverdale, Md.	
24a. REC'D BY REGISTRAR DATE NOV 23 '60		24b. REGISTRAR'S SIGNATURE [Signature]	



CERTIFICATE OF DEATH

Reg. Dist. No.

12891

12952

1. PLACE OF DEATH a. COUNTY <i>Prince George County</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Illinois</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Laurel</i>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Evanston</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Furling Apts. Main Street</i>		d. STREET ADDRESS <i>827 Brummel Ave</i>	e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <i>Leah</i> First <i>Estrin</i> Middle Last		4. DATE OF DEATH <i>Nov 3</i> 1960 Month Day Year	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) <i>69</i> yrs		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>at Home</i>	11. BIRTHPLACE (State or foreign country) <i>Russia</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Alex Estrin - Furling Apts - Main St</i> Address <i>Laurel Md</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral vascular accident</i> DUE TO <i>SSX</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Atherosclerosis</i> DUE TO (c) <i>Diabetes mellitus</i>			INTERVAL BETWEEN ONSET AND DEATH <i>90 min.</i> <i>104p.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>10/11</i> , 1960, to <i>11/3</i> , 1960, that I last saw the deceased alive on <i>11/3</i> , 1960, and that death occurred at <i>4 A.</i> M. from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED <i>James V. Weaver, Jr.</i> M.D. <i>320 Montgomery St., Laurel, Md.</i> <i>11/3/60</i>			
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>	22b. DATE THEREOF <i>Nov-3/60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Westlawn Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Chicago, Illinois</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. L. Lennan</i> ADDRESS <i>6010 Kewell Road</i>		24a. REC'D BY REGISTRAR DATE <i>NOV 7 '60</i>	24b. REGISTRAR'S SIGNATURE <i>Charles S. Hines</i>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12973

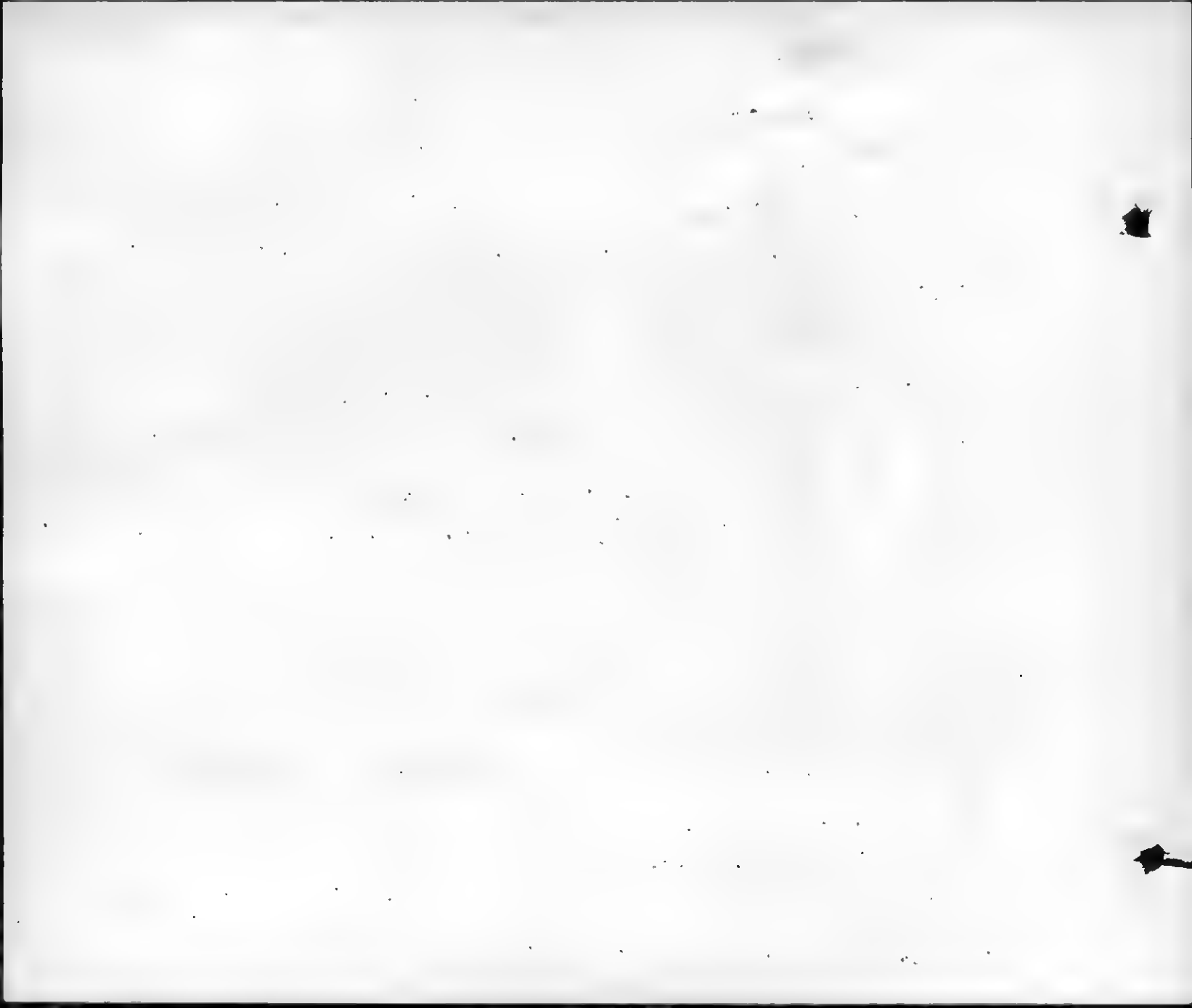
CERTIFICATE OF DEATH

12892

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Camp Springs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Falls Church	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAR Hospital Andrews		d. STREET ADDRESS 1413 Cavlier Corridor	
3. NAME OF DECEASED (Type or print) First Middle Last Mattie B Frazier		4. DATE OF DEATH Month Day Year November 8 19 60	
5. SEX Female	6. COLOR OR RACE Cau	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 22 SEP 1892
9. AGE (In years lost birthday) 68 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESLADY		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) SHAWNEE, OKAL.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME R RUBEN WALK		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT COL BRADLEY, 1413 CAVLIER CORR.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1955 DUE TO Bronchopneumonia, terminal (b) 1955 DUE TO Glioblastoma Multiforme (c) 1955 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 4 1/2 hours 6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTR BUT NO TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 19 to 19, that I last saw the deceased alive on 8 November 1960, and that death occurred at 4:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Paul Bittick Jr. M.D.			
PHYSICIAN'S NAME (Type) Paul Bittick Jr.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-12-60	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) Blackwell & Blakely	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS		24a. REC'D BY REGISTRAR DATE NOV 10 '60	
24b. REGISTRAR'S SIGNATURE		24c. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12909 **12892**

1. **PLACE OF DEATH**
a. COUNTY **Prince Georges County** **MARYLAND**
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **Cheverly**
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) **Prince Georges General Hospital**

2. **USUAL RESIDENCE** (Where deceased lived, if Institution; Residence before admission)
a. STATE **D. C.** b. COUNTY **None**
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **Washington**
d. STREET ADDRESS **1909 P Street S. E.**
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print)
GERMAINE CATHERINE FREDERICK

4. **DATE OF DEATH**
Date **November 22, 1960.**

5. **SEX** **Female** 6. **COLOR OR RACE** **White** 7. **MARRIED** ☒ NEVER MARRIED ☐ 8. **DATE OF BIRTH** **July 10, 1903** 9. **AGE** (In years (if UNDER 1 YEAR) last birthday) **57** yrs. 10. **USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired) **Clerk** 11. **BIRTHPLACE** (State or foreign country) **Washington, D. C.** 12. **CITIZEN OF WHAT COUNTRY?** **U.S.A.**

13. **FATHER'S NAME** **John C. Reuter** 14. **MOTHER'S MAIDEN NAME** **Jennie Cain**

15. **WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown) (If yes give year or dates of service) **No** 16. **SOCIAL SECURITY NO.** **unknown** 17. **INFORMANT** **Louis P. Frederick** Address **1909 P St., S.E. Washington, D. C.**

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c)]
PART I. **DEATH WAS CAUSED BY:**
IMMEDIATE CAUSE (a) **Coronary Occlusion**
DUE TO
Conditions, if any, which gave rise to immediate cause (b) **Hypertension Heart Disease**
(c), stating the underlying cause last.
PART II. **OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):**

19. **WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

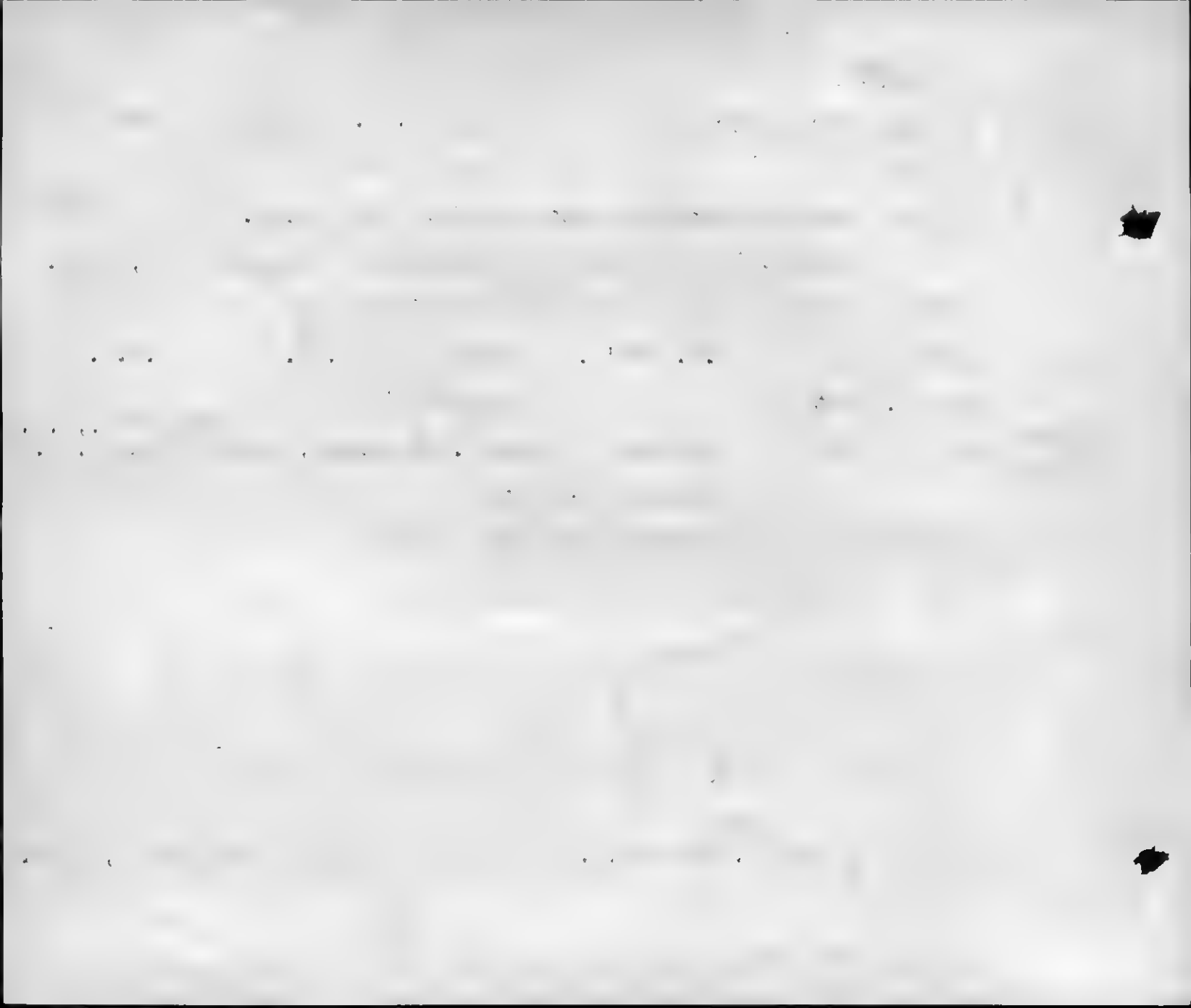
20a. **EXTERNAL CAUSE WAS PRIMARY** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH.** 20b. **DESCRIBE HOW INJURY OCCURRED.** (Enter nature of injury in Part I or Part II of item 18.)
20c. **TIME OF INJURY** Month, Day, Year 19 **White** ☐ **Not White** ☐ 20d. **INJURY OCCURRED** **While at work** ☐ **Not while at work** ☐ 20e. **PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.) 20f. **(City or town)** **(County)** **(State)**

21. **I certify that I took charge of the remains described above, held an Autopsy** ☐ **Inspection** ☒ **Inquiry** ☒ **and in my opinion death resulted from:** **Natural causes** ☒ **Accident** ☐ **Suicide** ☐ **Homicide** ☐ **Undetermined manner** ☐

ACTUAL SIGNATURE **JAMES I. BOYD, M.D.** **DATE SIGNED** **November 22, 1960.**
EXAMINER'S NAME (Type) **JAMES I. BOYD, M.D.**
CHIEF MEDICAL EXAMINER ☐ **ASS. STANT MEDICAL EXAMINER** ☐ **DEPUTY MEDICAL EXAMINER** ☒

22a. **BURIAL, CREMATION, REMOVAL (Specify)** **Burial** 22b. **DATE THEREOF** **11-25-1960** 22c. **NAME OF CEMETERY OR CREMATORY** **Sedar Hill** 22d. **LOCATION** (City, town, or country) **Frederick Md**

23. **FUNERAL DIRECTOR** **MATTINGLY FUNERAL HOME** **ADDRESS** **131-11th St Wash DC** 24a. **REC'D BY REGISTRAR** **NOV 28 '60** 24b. **REGISTRAR'S SIGNATURE**



TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12894

12910

Items 10, 11, 12, 13, 14 Film 226 12-6-60 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>And</u> b. COUNTY <u>Pr Geo</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>		c. LENGTH OF STAY IN 1b <u>5 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> X			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George General Hospital</u>				d. STREET ADDRESS <u>12512 Von Buren St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ADELLE GAVENKORT</u>				4. DATE OF DEATH Month Day Year <u>Nov 22 1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 8 1987</u>		9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Floor Lady</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Paper Box Factory</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Anthony Gavenkort (sic)</u>				14. MOTHER'S MAIDEN NAME <u>Frances (Last name unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-01-9454</u>		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac arrest</u> DUE TO <u>157X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Adrenal insufficiency</u> (c) <u>Ca fluid of Pancreas</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Metastasis to Adrenal gland & Liver</u>						INTERVAL BETWEEN ONSET AND DEATH <u>not</u> <u>Weeks</u> <u>Weeks</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>No</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Dayton O Watkins</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>DAYTON O WATKINS</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>10-25-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Funeral</u>		22b. DATE THEREOF <u>11/28/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Etchecop</u>		22d. LOCATION (City, town, or county) (State) <u>Balt Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank A. Smith</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 30 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton S. Kline</u>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cherry</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince Georges General Hospital</u>		d. STREET ADDRESS <u>32 - 17th Street SE</u>	
3. NAME OF <u>Lester</u> First Middle Last		4. DATE OF DEATH <u>Nov 11 1960</u> Month Day Year	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 29 1923</u> Test birth day yrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Administrative County DC Govt</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DC Govt</u>	
11. BIRTHPLACE (State or foreign country) <u>District of Columbia DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Leroy Gaynor</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes WWII</u>		16. SOCIAL SECURITY NO. <u>Informant</u> Address <u>Joyce Gaynor, same as #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 4. DUE TO <u>Coronary atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary atherosclerosis</u> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: <u>None</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19 <u>11/15/1960</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James J. Boyd</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>James J. Boyd</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/15/1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Fort Meyer, Virginia</u>	
23. FUNERAL DIRECTOR <u>Frederick Fox Home, Inc. 3890 14th St NW Washington, D.C.</u>		24a. REC'D BY REGISTRAR <u>DATE NOV 16 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kiana</u>		25. REGISTRAR'S SIGNATURE	



may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, pay the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12912

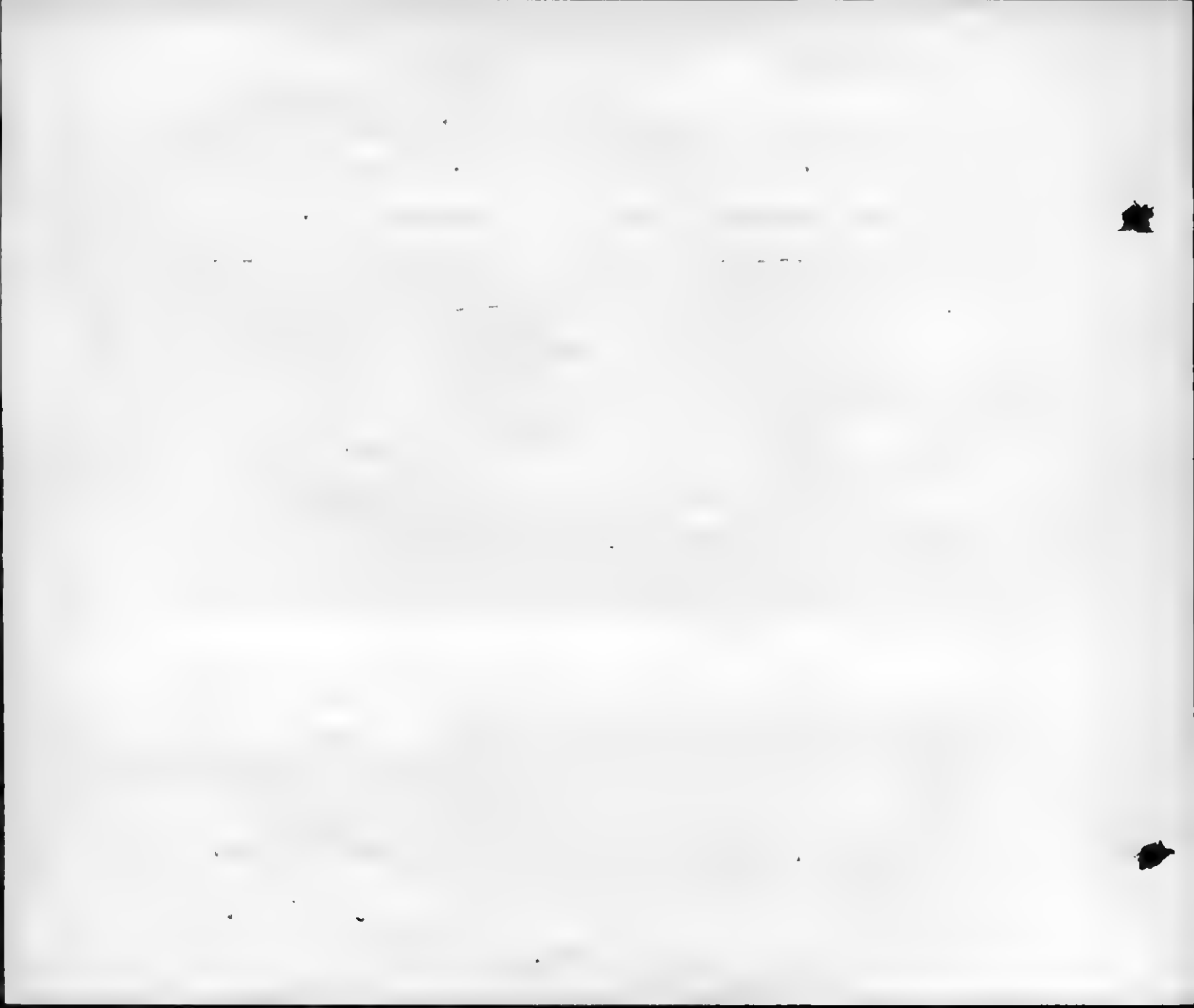
1

CERTIFICATE OF DEATH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12896

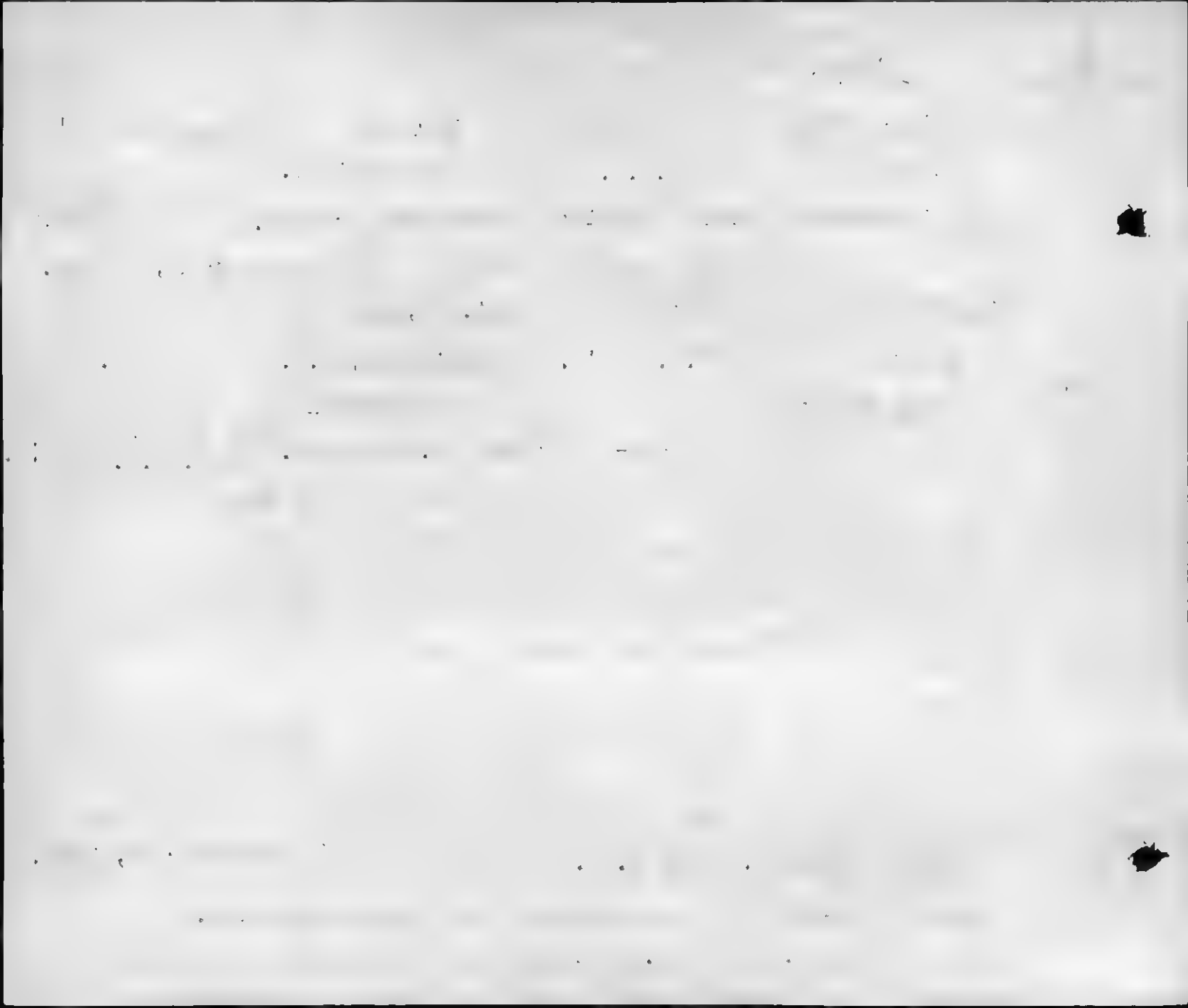
1 PLACE OF DEATH a. COUNTY Prince George MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE Md. b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Cheverly, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier			
c. LENGTH OF STAY IN 1b 11 days				d. STREET ADDRESS 4113 Rainier Ave.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) Lillian -Green- May Green				4. DATE OF DEATH 11-10-60			
5. SEX Fe.		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-12-82	
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of work ing life, even if retired) Clerk				10b. KIND OF BUSINESS OR INDUSTRY U.S. Government			
11. BIRTHPLACE (State or foreign country) Washington, D.C.				12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME John B. Baker				14. MOTHER'S MAIDEN NAME Catherine Whithead			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO 216-12-4314		17. INFORMANT Daughter Mrs. Catherine Peyton	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). Myocardial Infarction- left Ventricle DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b). Arteriosclerotic Heart Disease DUE TO (c). PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 1957 to 11/10, 1960, that (I) (we) last saw the deceased alive on 11/9, 1960, and that death occurred at 12:54 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Leon R. Levitsky M.D.				22b. DATE SIGNED 11/10/60			
22c. PHYSICIAN'S NAME (Type) Leon R. Levitsky				22d. ADDRESS 3408 Rhode Island Ave.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/12/1960		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City, town, or county) (State) Washington, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Valley's Funeral Home, Mt. Rainier, Md.				25. REC'D BY REGISTRAR DATE NOV 14 '60		25. REGISTRAR'S SIGNATURE Arthur S. Kline	



VS. AISME
SM 7/59

12897

1. PLACE OF DEATH a. COUNTY Prince George		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		b. COUNTY Prince George's	
c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Camp Springs	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George General Hospital		d. STREET ADDRESS 5202 Stanhaven Rd.	
3. NAME OF DECEASED (Type or print) MARY AGNES GREEN		4. DATE OF DEATH November 13, 1960	
5. SEX Female		6. DATE OF BIRTH Sept. 12, 1890	
6. COLOR OR RACE White		7. AGE (In years, if UNDER 1 YEAR, IF UNDER 24 HRS. last birthday) Months Days Hours Min 70	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? yes.	
13. FATHER'S NAME James Sullivan		14. MOTHER'S MAIDEN NAME Mary Shahan	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no		16. SOCIAL SECURITY NO. 577-38-1748	
17. INFORMANT Thomas F. Wert, Jr.		Address 5202 Stanhaven Rd. S.E.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute congestive heart failure 420.1 DUE TO (b) coronary occlusion Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED November 14, 1960 Address (Street, city, town, or county) 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 11-17-60 22c. NAME OF CEMETERY OR CREMATOR Arlington National 22d. LOCATION (City, town, or country) (State) Arlington, Va. 23. FUNERAL DIRECTOR James T. Ryan, Inc. 24a. REC'D BY REGISTRAR NOV 16 '60 24b. REGISTRAR'S SIGNATURE Charles E. Ryan			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

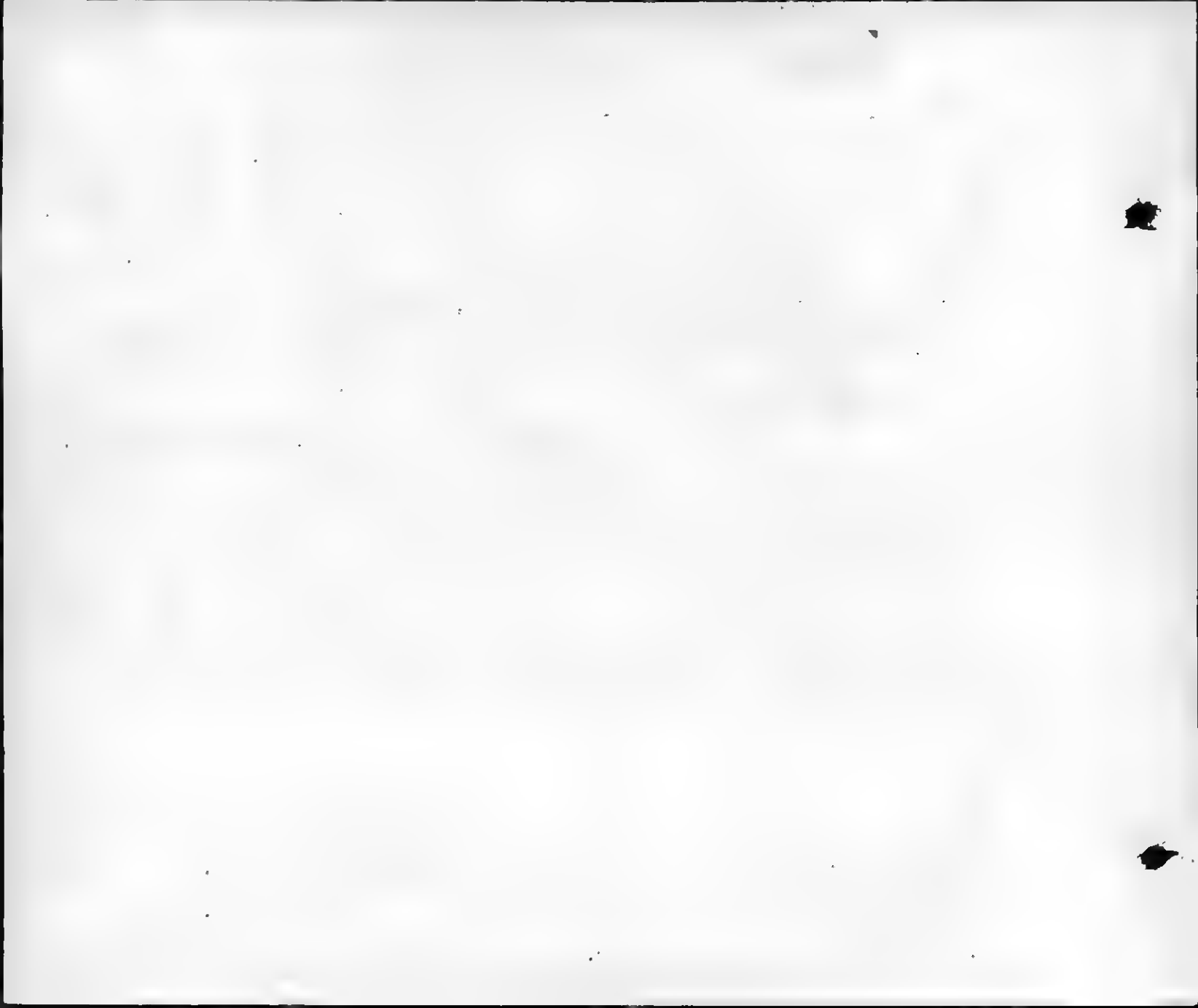
Reg. Dist. No.

12974

12898

1 PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) West Hyattsville Md c. LENGTH OF STAY IN 1b 1417 Madison Street d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1417 Madison Street		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Pri. Geo. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Hyattsville Md. d. STREET ADDRESS 1417 Madison Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Iola Middle Griffiths Last Griffiths		4 DATE OF DEATH Month November Day 18 Year 19 60-	
5 SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 25, 1883
9. AGE (In years lost birthday) 76 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11 BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U S A	
13 FATHER'S NAME George Peacock		14. MOTHER'S MAIDEN NAME Elizabeth Kirby	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16 SOCIAL SECURITY NO 577 10 0150	
17 INFORMANT Thelma Peacock		Address West Hyattsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) YEARS INTERVAL BETWEEN ONSET AND DEATH 2 MIN.			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I attended the deceased from AUG. 1956 to PRESENT , that I last saw the deceased alive on 14 Nov. 1960 , and that death occurred at 9:25 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 905 SHERIDAN ST. DATE SIGNED 11/18/60			
ACTUAL SIGNATURE Henry R. Wolfe		M.D. 905 SHERIDAN ST.	
PHYSICIAN'S NAME (Type) Henry R Wolfe		University Park, Md.	
22a BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov 22, 1960	
22c. NAME OF CEMETERY OR INTERMENT PLACE George Washington		22d LOCATION (City, town, or county) (State) Hyattsville Md.	
23 FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville Md.	
24a. REC'D BY REGISTRAR NOV 22 60		24b. REGISTRAR'S SIGNATURE Robert S. [unclear]	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

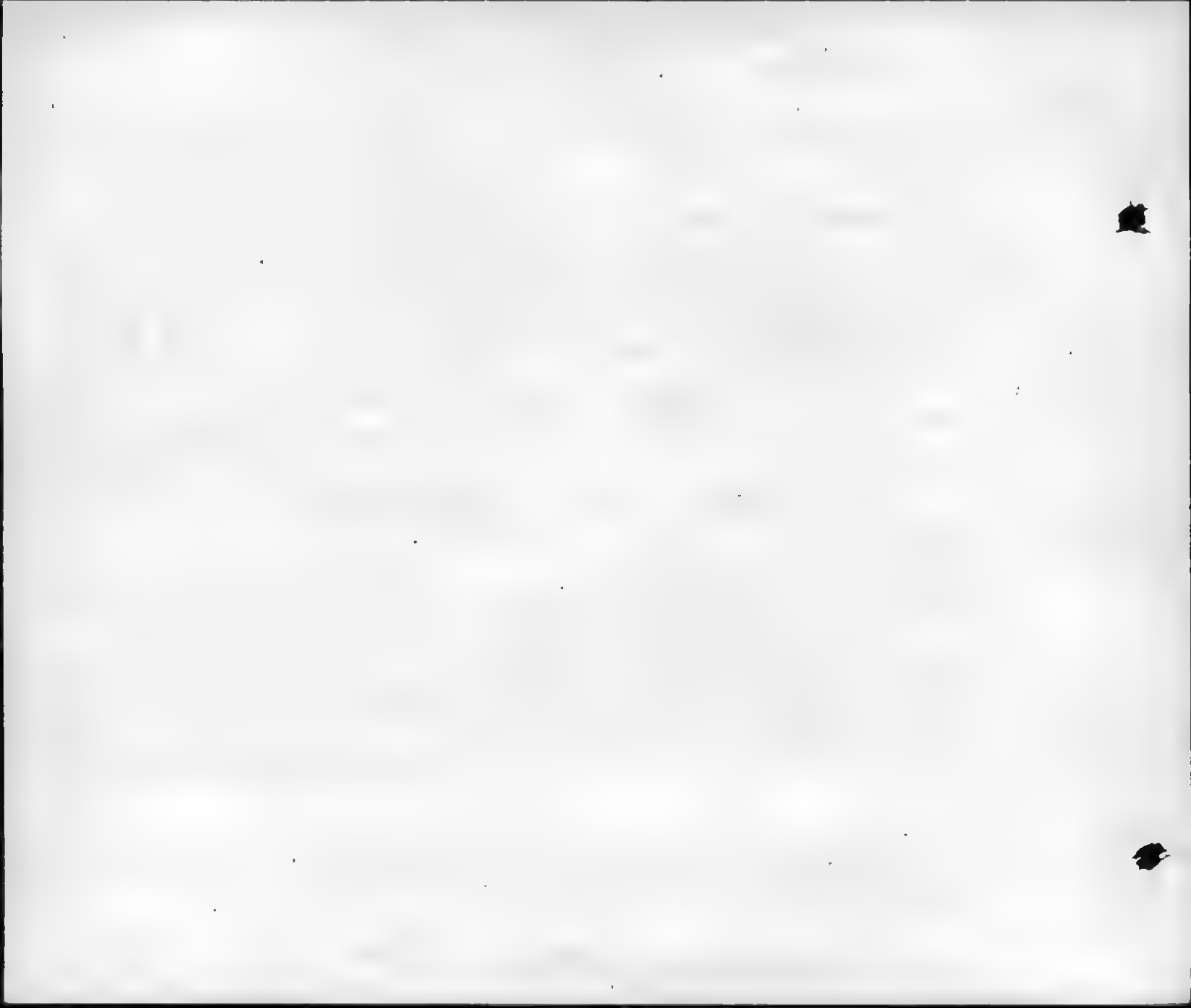
VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12914

12890

1 PLACE OF DEATH a COUNTY Prince George's MARYLAND				2 USUAL RESIDENCE (Where deceased lived If first listed on Residence before admission) a STATE Maryland b COUNTY Prince George's			
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Cheverly				c LENGTH OF STAY IN 1b 2 weeks			
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General Hospital				e STREET ADDRESS 1416 Colesville Road			
3 NAME OF DECEASED (Type or print) First Middle Last Lillian B Gruber				4 DATE OF DEATH Month Day Year Nov. 11 1960			
5 SEX Female		6 COLOR OR RACE White		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 10/6/84	
9 AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS. Hours Min			
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY own home		11 BIRTHPLACE (State or foreign country) England	
12 CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Burley				14. MOTHER'S MAIDEN NAME Emily ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17 INFORMANT Wilbur Lee Price Arlington Virginia			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarction, posterior + 20-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Coronary occlusion DUE TO (c) Coronary arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from Sept 1946 to Nov 11, 1960, that (I) (we) last saw the deceased alive on Nov 10, 1960, and that death occurred at 7:55 P.M. from the causes and on the date stated above.							
22a SIGNATURE Louis Mendel M.D.				22b. DATE SIGNED 11/11/60		22c. PHYSICIAN'S NAME (Type) Dr. Louis Mendel	
22d. ADDRESS 4506 College Ave. Collage Park, Maryland							
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City, town, or county) (State)	
Burial		11/14/60		Rock Creek		Washington D. C.	
24 FUNERAL DIRECTOR'S SIGNATURE Hersch's Funeral Home				ADDRESS Hyattsville, Md		25a. REC'D BY REGISTRAR DATE NOV 16 '60	
				25b REGISTRAR'S SIGNATURE Arthur S. Thomas			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

129.0

<p>12915</p> <p>1. PLACE OF DEATH a. COUNTY Prince George MARYLAND</p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly</p> <p>c. LENGTH OF STAY IN 1b 3 Days</p> <p>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pr. Geo. Gen. Hosp.</p>				<p>2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)</p> <p>a. STATE Maryland b. COUNTY Pr. Geo.</p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville</p> <p>d. STREET ADDRESS 4011 Forest Road</p> <p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>			
<p>3. NAME OF DECEASED (Type or print)</p> <p>First JAMES Middle GUTHRIE Last</p>			<p>4. DATE OF DEATH</p> <p>Month Nov. Day 29 Year 19 60</p>				
<p>5. SEX Male</p>		<p>6. COLOR OR RACE White</p>		<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>			
<p>8. DATE OF BIRTH 26 Sept 1910</p>		<p>9. AGE (In years last birthday) 50 yrs.</p>		<p>IF UNDER 1 YEAR Months Days Hours Min.</p>			
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Veterinarian</p>		<p>10b. KIND OF BUSINESS OR INDUSTRY U S Government</p>		<p>11. BIRTHPLACE (State or foreign country) Indiana</p>			
<p>12. CITIZEN OF WHAT COUNTRY? U.S.A.</p>							
<p>13. FATHER'S NAME Truman Guthrie</p>			<p>14. MOTHER'S MAIDEN NAME Mable Roberts</p>				
<p>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no</p>		<p>16. SOCIAL SECURITY NO.</p>		<p>17. INFORMANT Magdelene Guthrie Address (Wife) Same as # 2</p>			
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiphase lacerations Liver, Rtx</p> <p>Conditions, if any, which gave rise to immediate cause (b) Pentona Hemorrhage, Multiphase 3 days</p> <p>(c) Rib fractures, Rt Hemithorax (Trauma)</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Calcific aortic stenosis secondary to Rheumatism</p> <p>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>							
<p>20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/></p>		<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Heart disease</p>					
<p>20c. TIME OF INJURY Month, Day, Year</p> <p>Hour 11 a. m. 30 p. m.</p>		<p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/></p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) street</p>			
<p>20f. (City or town) St Paul (County) Indiana (State)</p>							
<p>21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>.</p>							
<p>ACTUAL SIGNATURE Dayton O Wattenis</p>			<p>DATE SIGNED 11-29-60</p>				
<p>EXAMINER'S NAME (Type) DAYTON O WATTENIS</p>			<p>CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/></p>				
<p>22a. BURIAL, CREMATION, REMOVAL (Specify) Transportation</p>		<p>22b. DATE THEREOF 11/30/60</p>		<p>22c. NAME OF CEMETERY OR CREMATORY St Paul</p>			
<p>22d. LOCATION (City, town, or county) Indiana (State)</p>							
<p>23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons ADDRESS Hyattsville, Md.</p>			<p>24a. REC'D BY REGISTRAR DEC 1 '60</p>				
<p>24b. REGISTRAR'S SIGNATURE C. J. Smith</p>							

TO DEPT. OF HEALTH: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose a "pending" certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



CERTIFICATE OF DEATH

Reg. Dist. No. 129-1

12891

1 PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE, 620 SHERIDAN STREET</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>620 Sheridan Street</u>				e. STREET ADDRESS <u>620 SHERIDAN STREET</u>			
3 NAME OF DECEASED (Type or print) First <u>GERTRUDE</u> Middle <u>LAVELLE</u> Last <u>HALEY</u>				4 DATE OF DEATH Month <u>NOV</u> Day <u>3</u> Year <u>1960</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCTOBER 25, 1900</u>	
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>		IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CONSELMAN</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>EMPLOYMENT AGENCY</u>		11. BIRTHPLACE (State or foreign country) <u>GEMON SOUTH DAKOTA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>JOHN E. HALEY</u>				14. MOTHER'S MAIDEN NAME <u>KATHERINE LAVELLE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO <u> </u>		17. INFORMANT <u>MRS. JOHN ROQUEVERT</u> Address <u>812 COX AVE. HYATTSVILLE, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive heart disease</u> DUE TO (c) <u> </u>							
INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>11:00</u> , 19 <u>58</u> , to <u>present</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Nov 3</u> , 19 <u>60</u> , and that death occurred at <u>5:30 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William F. Simpson</u> M.D.				DATE SIGNED <u>11/3/60</u>			
PHYSICIAN'S NAME (Type) <u>William F. Simpson</u>				<u>Washington, D.C.</u>			
22a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Nov 9, 1960</u>		<u>Holy Name Cemetery</u>		<u>Rock Rapids, Iowa</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William F. Simpson</u>				ADDRESS <u>254 Carroll St. N.W. N.C.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 7 '60</u>	
24b. REGISTRAR'S SIGNATURE <u> </u>							

TO HUSBAND OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12975

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12912

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>East Riverdale</u>				c. LENGTH OF STAY IN 1b <u>13 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>DR. Prince George General Hospital</u>				d. STREET ADDRESS <u>17710 63 rd Ave</u>			
3. NAME OF DECEASED (Type or print) First <u>Norman</u> Middle <u>Belle</u> Last <u>Hall</u>				4. DATE OF DEATH Month <u>11</u> Day <u>17</u> Year <u>1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 2 1904</u>	9. AGE (in years last birthday) <u>51</u> yrs	IF UNDER 1 YEAR Months <u>1</u> Days <u>15</u>	IF UNDER 24 HRS Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MARILAND</u>	12. CITIZEN OF WHAT COUNTRY? <u>US</u>
13. FATHER'S NAME <u>George E. Buyer</u>				14. MOTHER'S MAIDEN NAME <u>Winn</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>James M. Hall</u> Address <u>17710 63 rd Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Auricular Fibrillation</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u></u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	
20f. (City or town) <u></u> (County) <u></u> (State) <u></u>							
21. I certify that (I) (this hospital) attended the deceased from <u>Oct</u> 19 <u>58</u> to <u>present</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>11-17-60</u> 19 <u>60</u> , and that death occurred at <u>11 PM</u> , from the causes and on the date stated above							
22a. SIGNATURE <u>William C. Weintraub</u>				22b. DATE SIGNED <u>11-17-60</u>		22c. PHYSICIAN'S NAME (Type) <u>WILLIAM C. WEINTRAUB, M.D.</u>	
22d. ADDRESS <u>6-100 6th St, Prince Georges</u>				22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>Nov. 21, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City, town, or county) <u></u> (State) <u></u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Charles Co. Kincadeo</u>				25a. REC'D BY REGISTRAR <u></u> DATE <u>NOV 21 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	



Cirrus P 4



12976

CERTIFICATE OF DEATH

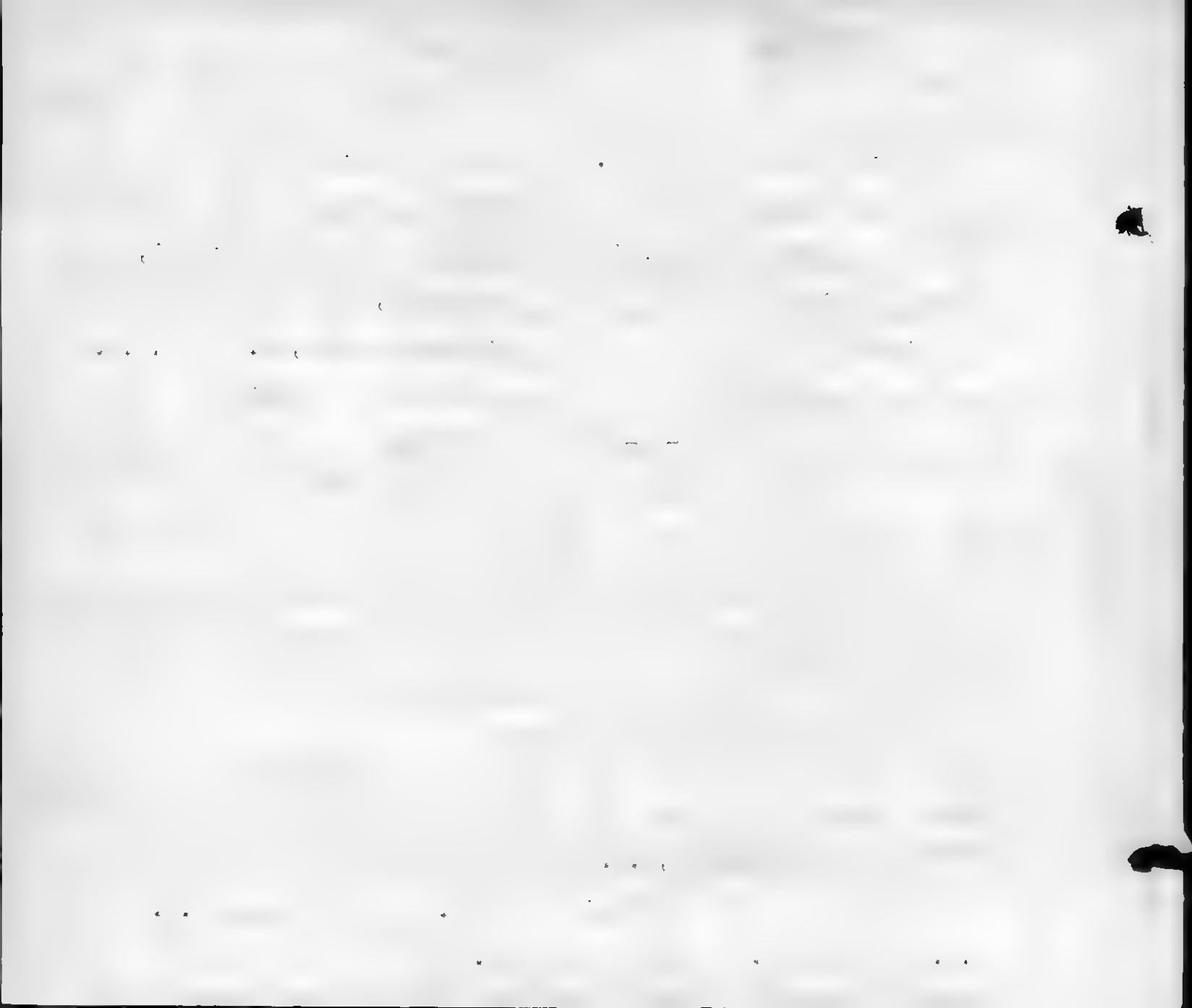
Reg. Dist. No.

12976

1. PLACE OF DEATH a. COUNTY Prince Georges		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rogers Heights		c. LENGTH OF STAY IN 1b 50yrs.		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5020 56 Avenue		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rogers Heights		f. STREET ADDRESS 5020 56 Avenue		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Glenn Middle Audleigh Last Hynson		4. DATE OF DEATH Month November Day 27 Year 1960							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 8, 1900		9. AGE (in years last birthday) 60 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Richmond County, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Addison Glenn Hynson		14. MOTHER'S MAIDEN NAME Laura Belle Lampkin							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 577-10-1224		17. INFORMANT Jane Thomas		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro Vascular Accident 163 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ca of Lung DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan 1958 to Nov 27 1960 that I last saw the deceased alive on 11/27 19 60 and that death occurred at 1:10 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 5102 annapolis Rd		DATE SIGNED 11/28/60					
ACTUAL SIGNATURE Barry Rosenberg		M.D. 5102 annapolis Rd							
PHYSICIAN'S NAME (Type) Barry Rosenberg, M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-27-60		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem.		22d. LOCATION (City, town, or county) (State) Washington D.C.			
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co.		ADDRESS Riverdale, Md.		24a. REC'D BY REGISTRAR DATE NOV 29 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Thomas			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. The page remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12917

Item 7 Milm 6216 12-5-60 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>		c. LENGTH OF STAY IN It <u>2 mo 15 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>RUFUS SAMUEL JACKSON</u>		4. DATE OF DEATH <u>Nov 27 1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 8 1908</u>
9. AGE (In years last birthday) <u>52</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Henry Jackson</u>		14. MOTHER'S MAIDEN NAME <u>Susan Whitely</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>5028 0018 01</u>	
17. INFORMANT <u>Henry Jackson</u>		Address <u>5028 Conquest ST NE Washington DC</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Confluent Bronchopneumonia</u> <u>cond.</u> DUE TO (b) <u>Massive Cerebral Necrosis RT</u> <u>2 mo 15 days</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Subdural hematoma RT</u> <u>2 mo 10 days</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>unknown</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>Unknown</u> p. m. <u>Unknown</u>		20d. INJURY OCCURRED. <u>While at work</u> <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Unknown</u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input checked="" type="checkbox"/> .			
ACTUAL SIGNATURE <u>Dayton O Watkins</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>DAYTON O WATKINS</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Nov 27-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>12/1/60</u>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Mem. Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Suitland Rd. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>11 S. Washington</u>		ADDRESS <u>4925 Denne Ave NE</u>	
24a. REC'D BY REGISTRAR <u>DATE 1 60</u>		24b. REGISTRAR'S SIGNATURE	

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

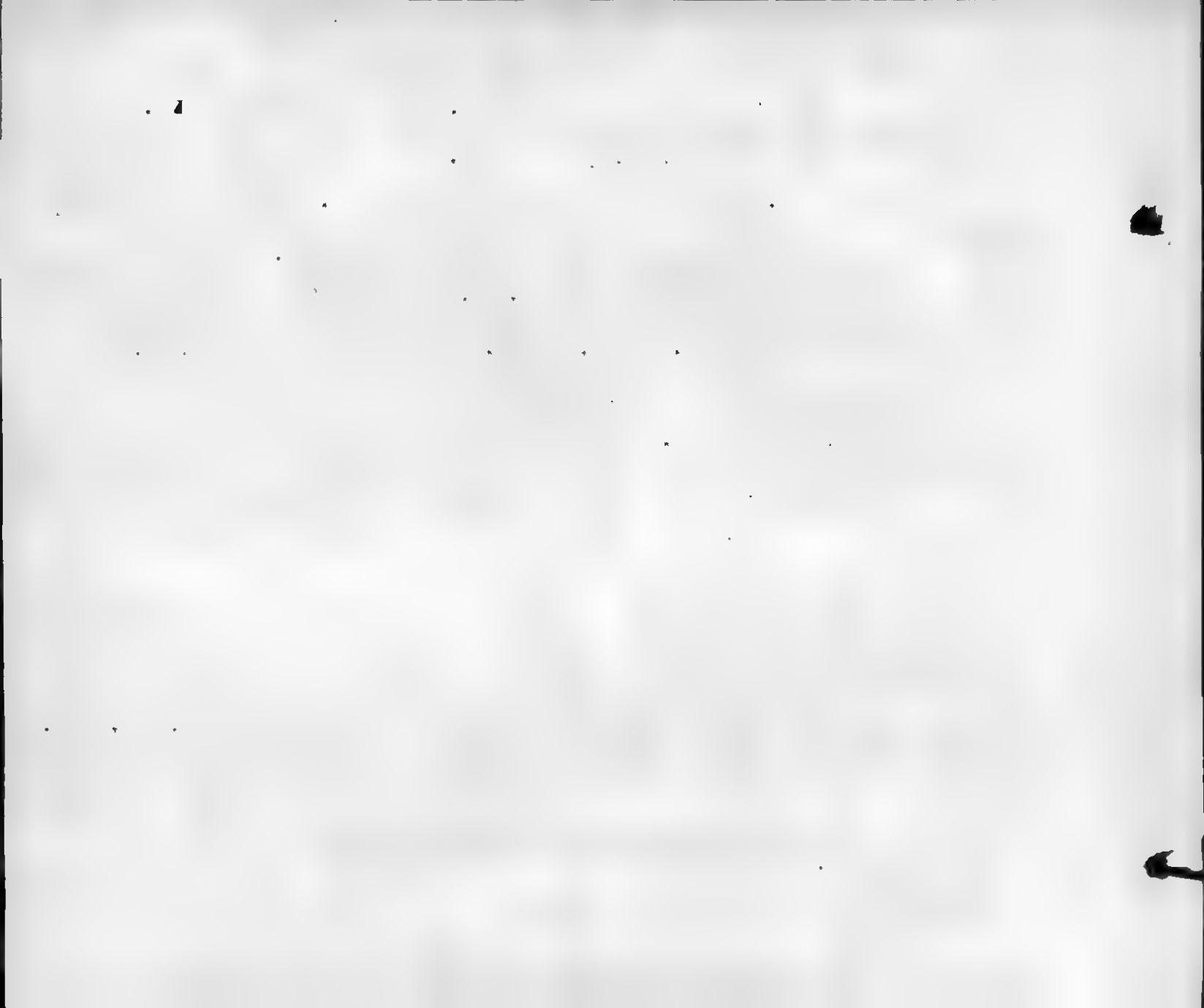
12957 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

129 7

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Ieland Memorial Hosp.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Balto.	
3. NAME OF DECEASED (Type or print) CHARLES First ARTHUR Middle JOHNSON Last		4. DATE OF DEATH Month NOV. Day 5 Year 19 60	
5 SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 21, 1889 1898
9. AGE (In years from birthday) 62 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Balto. Gas Co.	
11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Johnson		14. MOTHER'S MAIDEN NAME Nancy Walls	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Unk.	
17. INFORMANT Lucille Johnson		Address Same as # 2 (Wife)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Surgical Shock DUE TO (b) Cerebral hemorrhage & rupture Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) Fractured skull moments PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Subject struck by Auto on Highway 20c. TIME OF INJURY Month, Day, Year 6:45P a.m. 11/5 1960 20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway 20f. (City or town) (County) (State) College Park Pr. Geo. Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Dayton O. Watkins		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Dayton O. Watkins		DATE SIGNED 11-6-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/10/ 60	22c. NAME OF CEMETERY OR CREMATORY Baltimore National	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Charles A. Rice		ADDRESS 661 W. Barre Street	
24a. REC'D BY REGISTRAR DATE NOV 3 '60		24b. REGISTRAR'S SIGNATURE Charles A. Rice	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

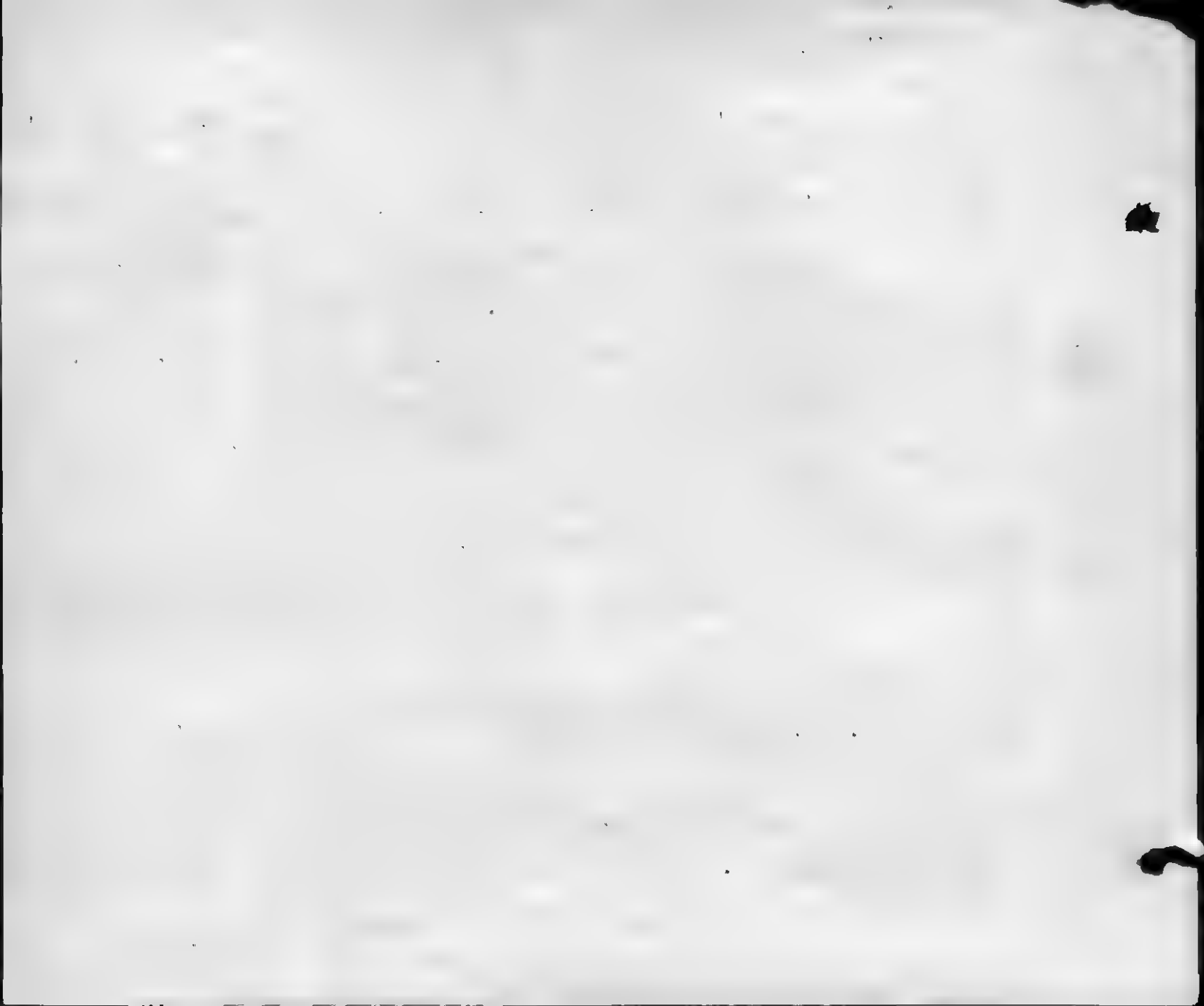
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

129 8

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if a day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		e. STREET ADDRESS 11907 Ellington Drive	
3. NAME OF DECEASED (Type or print) Clarence Johnson		4. DATE OF DEATH November 19, 1960	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Oct. 2, 1958
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Elmore Johnson		14. MOTHER'S MAIDEN NAME Margaret Thomas	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. Margaret Helena Thomas, same as # 2	
17. INFORMANT Margaret Helena Thomas, same as # 2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 872.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) Salicylate poisoning (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Ingested salicylates	
20c. TIME OF INJURY Month, Day, Year Nov. 19, 1960 Hour a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) (County) (State) Beltsville P. G. Md
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		DATE SIGNED November 19, 1960	
EXAMINER'S NAME (Type) James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) 11-23-61		22b. DATE THEREOF 11-23-61	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or country) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR Henry J. Puchner		24a. WITNESSED BY REGISTERAR NOV 28 1960	
ADDRESS 4625 Reisterstown Rd		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	



1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b 31			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 42 Cheverly	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General				d. STREET ADDRESS 2808 Laurel Ave.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Frank Middle G. Last Kohler				4. DATE OF DEATH Month Nov. Day 24 Year 1960			
5. SEX Male	6. CO. OR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-26-94	9. AGE (In years last birthday) 66 yrs	10. IF UNDER 1 YEAR Months Days Hours Min. 		10. IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Stationery Engineer			10b. KIND OF BUSINESS OR INDUSTRY Germany			11. BIRTHPLACE (State or foreign country) U S A	
12. CITIZEN OF WHAT COUNTRY? U S A				13. FATHER'S NAME Unknown			
14. MOTHER'S MAIDEN NAME Bertha Miller				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) --			
16. SOCIAL SECURITY NO. --				17. INFORMANT Ella Hedges Cheverly, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 163X DUE TO From the pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Epidemic and Paro. Both Left Lung (c) 							
PART II. OTHER SIGNIFICANT CONDITIONS CONTR BUT NG TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-25-1960 to 11-24-1960 , that (I) (we) last saw the deceased alive on 11-24-1960 , and that death occurred at 9:05 AM the causes and on the date stated above.							
22a. SIGNATURE A. Deitz M.D.				22b. DATE 11-26-60			
22c. PHYSICIAN'S NAME (Type) A. Deitz M.D.				22d. ADDRESS Hyattsville, Md.			
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov 26, 1960		23c. NAME OF CEMETERY OR CREMATORY Washington National		23d. LOCATION (City, town, or county) (State) Suitland Md.	
24. FUNERAL DIRECTOR'S SIGNATURE G. Gasch's Sons Hyattsville, Md.				25a. REC'D BY REGISTRAR DATE NOV 29 '60		25b. REGISTRAR'S SIGNATURE Charles S. Howard	



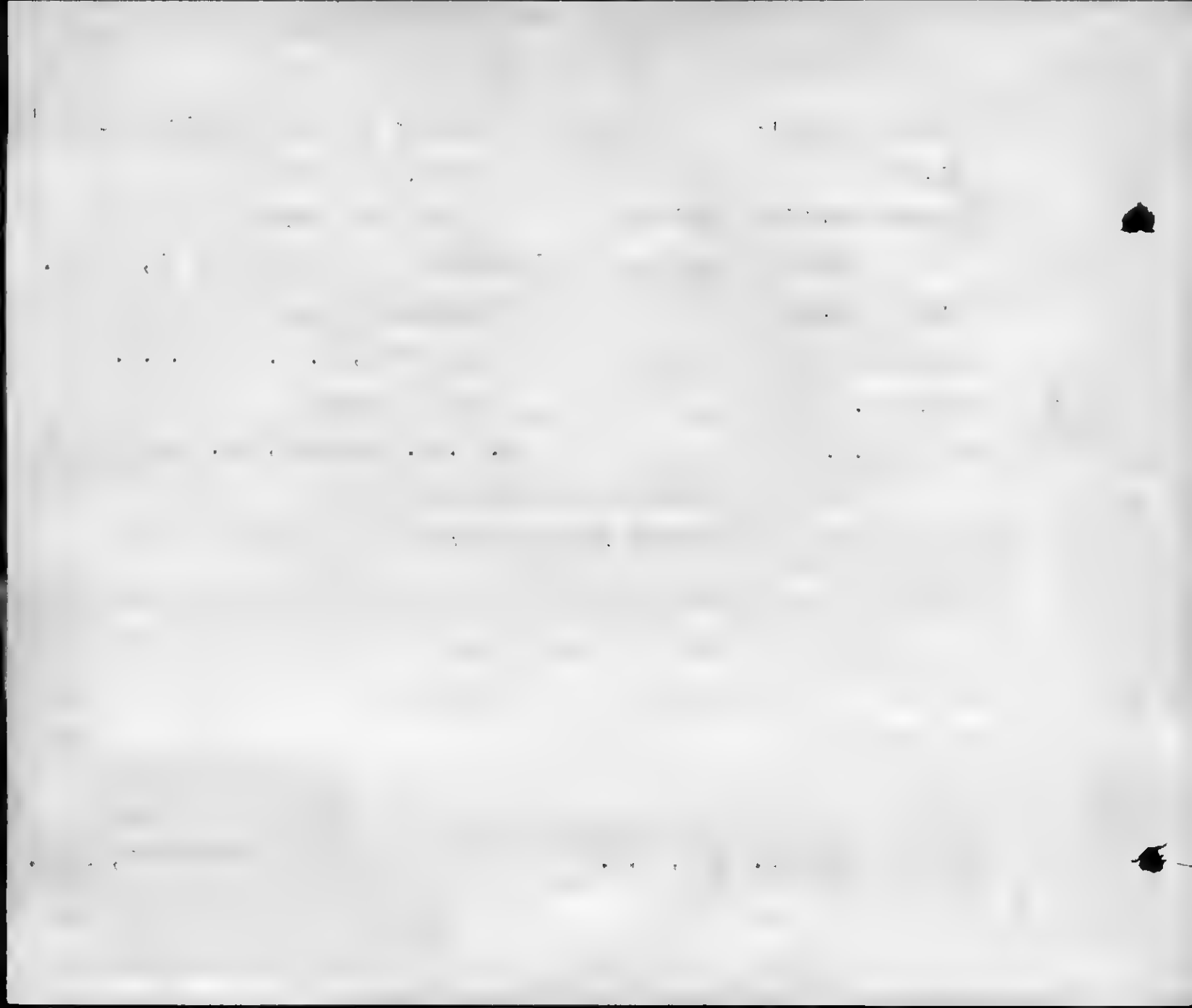
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
12958 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West, Hyattsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital		d. STREET ADDRESS 5602-37th Avenue	
3. NAME OF DECEASED (Type or print) CARRIE VIRGINIA LAMPHIER		4. DATE OF DEATH November 11, 19 60.	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 11/17/1899
9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Matthew S. Mckeown		14. MOTHER'S MAIDEN NAME Olive Nichols	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes W.W.I.		16. SOCIAL SECURITY NO. Mr. L. I. Lamphier, Sr.	
17. INFORMANT Same as #2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracranial Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, a.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/15/60	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		22d. LOCATION (City, town, or country) (State) Colmar Manor, Prince Georges, Md	
23. FUNERAL DIRECTOR Nalley's Funeral Home		ADDRESS Wt. Rainier Md.	
24a. REC'D BY REGISTRAR NOV 16 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



12977

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY PR. GEO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLINTON		c. LENGTH OF STAY IN 1b 19 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SOUTHERN MARYLAND HOSP. CENTER 1 RT 3 BOX 66		e. STREET ADDRESS BRANDYLOINE (RURAL)	
3. NAME OF DECEASED (Type or print) First Middle Last WILHELMINA — LANCE		4. DATE OF DEATH Month Day Year NOV. 27 1960	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 23, 1894
9. AGE (In years last birthday) 66 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) CANADA		12. CITIZEN OF WHAT COUNTRY? CANADA	
13. FATHER'S NAME WILLIAM SCHALIN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT GUSTAV LANCE - HUSBAND		Address RT 3 BOX 66 BRANDYLOINE MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) G.I. TRACT HEMORRHAGE, UREMIA DUE TO (b) SEPTICEMIA WITH PYELONEPHRITIS DUE TO (c) DIABETES MELLITIS		INTERVAL BETWEEN ONSET AND DEATH 4 HRS. 23 DAYS 23 DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) CHOLE	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. NONE	20d. INJURY OCCURRED NONE	20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) NONE	20f. (City or town) (County) (State) NONE
21. I certify that I attended the deceased from Nov. 8, 1960 to Present , that I last saw the deceased alive on Nov. 26, 1960 , and that death occurred at 9:15 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Arthur Shaver M.D.		DATE SIGNED 11/27/60	
PHYSICIAN'S NAME (Type) ARTHUR SHAVER TR MD BRANCH AVE. CLINTON, MD. 4/27/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-30-60	22c. NAME OF CEMETERY OR CREMATORY Trinity Mem. Gardens Waldorf (Ches) MD	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE Hermina Boyd ADDRESS 1661 - Good Hope Rd SE WASH DC		24a. REC'D BY REGISTRAR DATE NOV 29 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Phares	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12953

CERTIFICATE OF DEATH

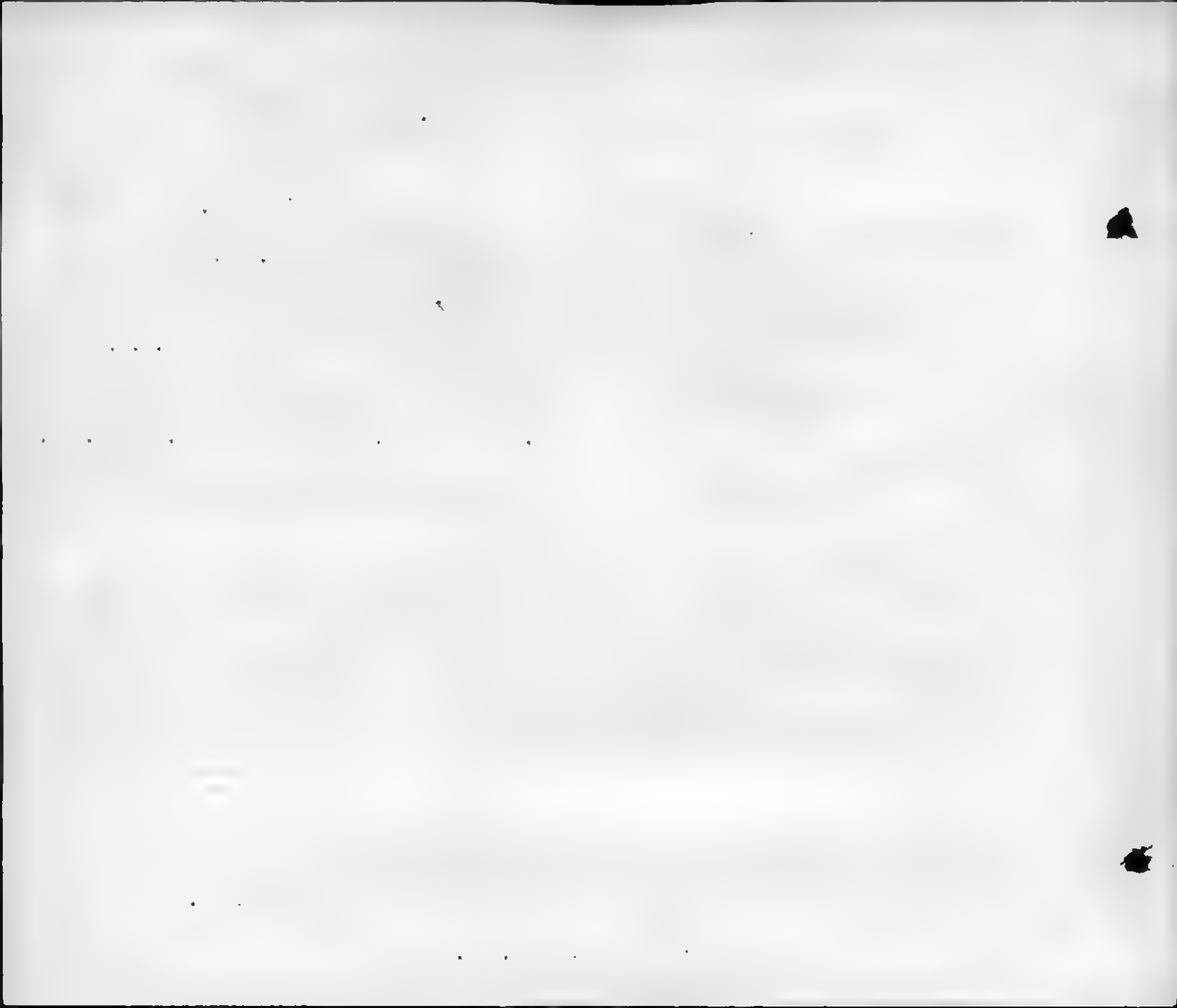
Reg. Dist. No.

12912

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Laurel General Hospital		d. STREET ADDRESS 4212 Park Heights Ave.	
3. NAME OF DECEASED (Also Lena or Lina) (Type or print) Antoinette (NMI) LaRosa		4. DATE OF DEATH Nov. 27, 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 25, 1887
9. AGE (In years last birthday) 73		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Salvatore Cucina		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Mrs. Rosa Damico, 4300 Woodridge Rd. Balto. Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage & Cardiac Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Cerebral Hemorrhage & Cardiac Failure DUE TO (c) Cerebral Hemorrhage & Cardiac Failure			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 11-16, 1960, to 11-27, 1960, that I last saw the deceased alive on 11-26, 1960, and that death occurred at 12:05 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Adolfo Pirandrea - M.D.		ADDRESS (Street, city or town, state) 305 Prince George St. Laurel, Md.	
DATE SIGNED 11-27-60			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/30/60	22c. NAME OF CEMETERY OR CREMATORY Cathedral Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE C. Vernon Lemmon, 4611 Park Heights, Balto. Md.		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
DATE NOV 29 '60			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



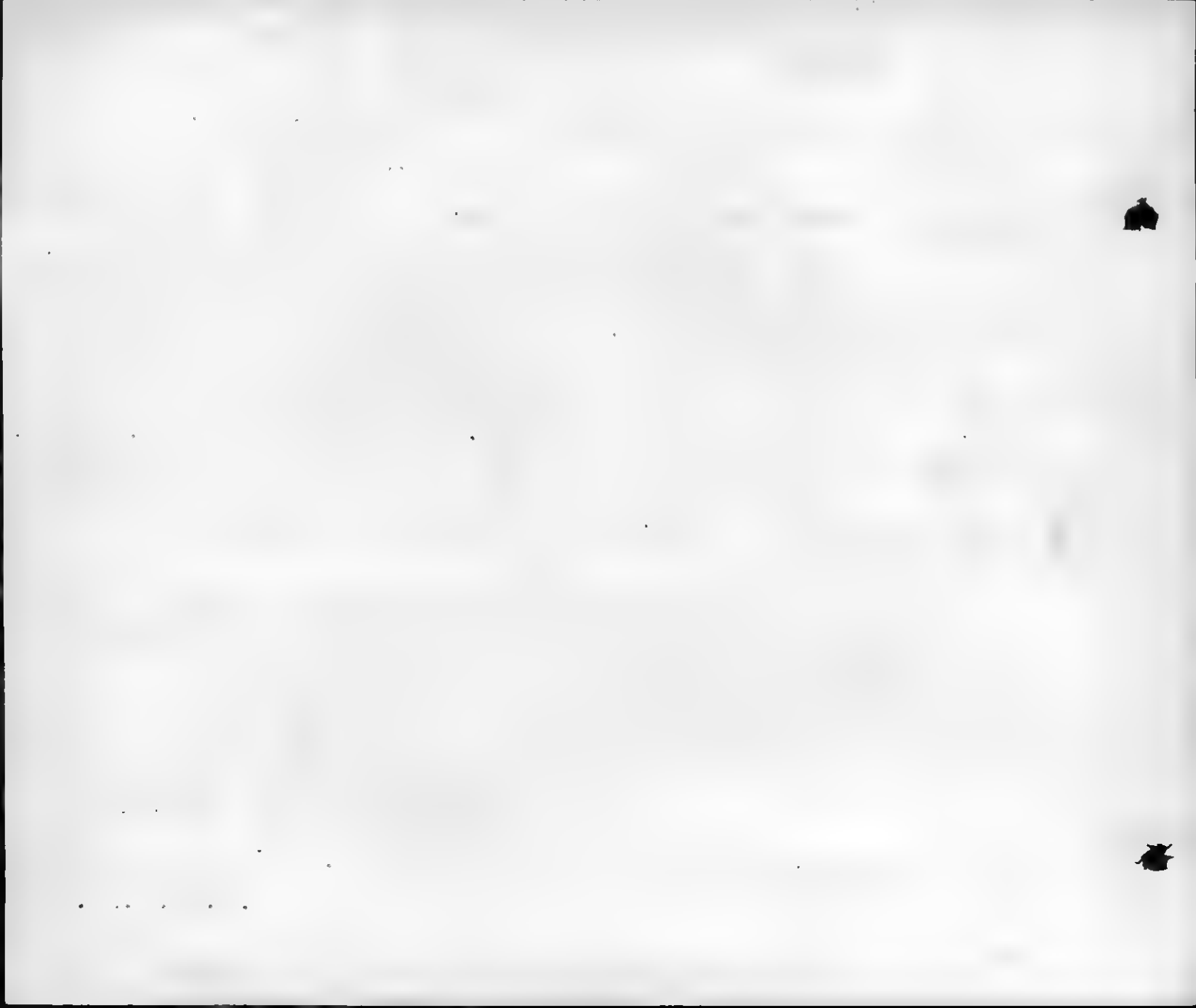
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12920

12913

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE W-sh., 22 D.C. b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Choverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) W sh., 22, D.C.	
c. LENGTH OF STAY IN 1b 2 days		d. STREET ADDRESS 6997 Allentown Rd	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) George (NMN) Lincoln		4. DATE OF DEATH November 24 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/20/1891
9. AGE (In years lost birthday) 69 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stationary Engineer Retired		10b. KIND OF BUSINESS OR INDUSTRY Retired US Gov't	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Eugene Lincoln		14. MOTHER'S MAIDEN NAME Mary Elizabeth Phelps	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None	
17. INFORMANT George F. Lincoln, 5726 East Pines Dr. Riverdale, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute pul. edema DUE TO (b) Arterio sclerosis of h'dog. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov. 22, 1960, to Nov. 24, 1960, that (I) (we) last saw the deceased alive on 11/24/1960, and that death occurred at 10:45 PM the causes and on the date stated above.			
22a. SIGNATURE Albert Roth		22b. DATE SIGNED 11/25/1960	
22c. PHYSICIAN'S NAME (Type) Albert Roth		22d. ADDRESS 5510 Madison Street, Riverdale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/29/1960	
23c. NAME OF CEMETERY OR CREMATORY Washington Nat'l Cemetery		23d. LOCATION (City, town, or county) (State) Suitland Rd. Pr. Geo. Co., Md.	
24. FUNERAL DIRECTOR'S SIGNATURE W. W. CHAMBERS CO. Riverdale, Md		25a. REC'D BY REGISTRAR NOV 29 '60	
ADDRESS		25b. REGISTRAR'S SIGNATURE Arthur J. K...	



<div>Item 23 Film 274 11-10-60</div> <div>12978</div> <div> <div>11-10-60</div> <div>11-13-14</div> <div>11-13-61</div> </div> <div> <div>12914</div> <div>43X-3</div> </div>											
<div> <div>11-10-60</div> <div>11-13-14</div> <div>11-13-61</div> </div> <div> <div>12914</div> <div>43X-3</div> </div>						<div> <div>11-10-60</div> <div>11-13-14</div> <div>11-13-61</div> </div> <div> <div>12914</div> <div>43X-3</div> </div>					
1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE c. LENGTH OF STAY IN lb 15 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSP ANDREWS, ANDREWS AFB, WASH, DC						2. USUAL RESIDENCE (Where deceased lived If institution Residence before admision) a. STATE CALIFORNIA b. COUNTY FRESNO c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FRESNO d. STREET ADDRESS 3019 HEDGES STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) EDWIN WILLIAM LIPPINCOTT First Middle Last 5 SEX MALE 6 COLOR OR RACE CAUCASIAN 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH 20 June 1920 9 AGE (In years last birthday) 40 yrs IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min						4. DATE OF DEATH Month NOVEMBER Day 10 Year 19 60 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) US AIR FORCE 10b. KIND OF BUSINESS OR INDUSTRY US AIR FORCE 11 BIRTHPLACE (State or foreign country) Oregon 12. CITIZEN OF WHAT COUNTRY? UNITED STATES					
13. FATHER'S NAME Fred S. Lippincott, Jr. 14. MOTHER'S MAIDEN NAME Elizabeth (maiden name unknown)						15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES 16. SOCIAL SECURITY NO. 1941-46 51-60 723-120-4850 17 INFORMANT HOSPITAL AND PERSONNEL RECORDS Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ARRHYTHMIA DUE TO Disturbance in heart rhythm Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Disturbance in heart rhythm DUE TO WOLFF PARKINSON WHITE SYNDROME (c) unknown PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) unknown 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year 27 Oct 19 60 Hour a. m. 10 p. m. 10 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 11511 20f. (City or town) FRESNO (County) CALIFORNIA (State)											
21. I certify that (I) (this hospital) attended the deceased from 27 Oct 19 60 to 10 Nov 19 60 that (I) (we) last saw the deceased alive on 10 Nov 19 60 and that death occurred at 11511 from the causes and on the date stated above. 22a. SIGNATURE Edwin E. Westura M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) EDWIN E WESTURA CAPT USAF MC 22d. ADDRESS USAF HOSP ANDREWS, ANDREWS AFB, WASH 25, DC 22b. DATE SIGNED 10 Nov 60											
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE THEREOF Nov. 16, 1960 23c. NAME OF CEMETERY OR CREMATORY WASHINGTON 23d. LOCATION (City, town, or county) FRESNO CALIFORNIA (State)											
24. FUNERAL DIRECTOR'S SIGNATURE RINALDI FUNERAL HOME ADDRESS 816 H ST. NE, DC 2 25a. REC'D BY REGISTRAR DATE NOV 14 '60 25b. REGISTRAR'S SIGNATURE Arthur S. Kline											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

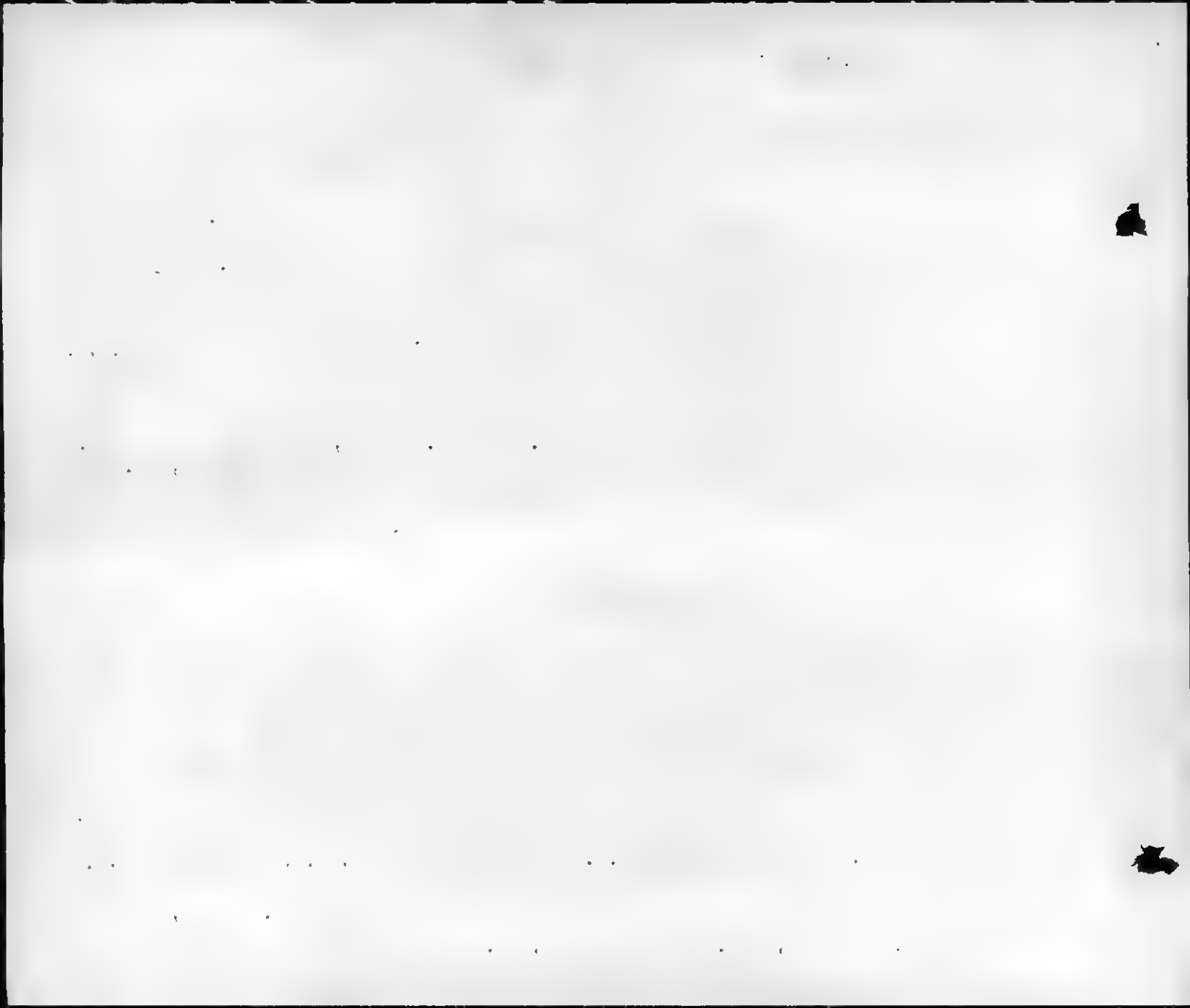
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12921

12915

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 18 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. STREET ADDRESS 8621 Piney Branch Rd.			
3. NAME OF DECEASED (Type or print) Lena Miller Little				4. DATE OF DEATH Month Nov. Day 5 Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7 October 1888		9. AGE (In years last birthday) 72 yrs	10. IF UNDER 1 YEAR Months 5 Days 19 Hours 60	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker				10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) NEW JERSEY	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME GEORGE MILLER				14. MOTHER'S MAIDEN NAME PHEBE STRYKER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. yes		17. INFORMANT Mr. Frank H. Little, 8621 Piney Branch Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 154X DUE TO Myeloma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Adenocarcinoma of the prostate (c) Adenocarcinoma of the kidney				INTERVAL BETWEEN ONSET AND DEATH 4 1/2 hrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 10/12 19 60 to 11/5 19 60 , that (I) (we) last saw the deceased alive on 11/5 19 60 , and that death occurred at 3:15 PM from the causes and on the date stated above.							
22a. SIGNATURE Saul Schwartzbach				22b. DATE SIGNED 11/5/60			
22c. PHYSICIAN'S NAME (Type) Dr. Saul Schwartzbach M.D.				22d. ADDRESS 1726 Eye St. N.W. Washington, D.C.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11/7/60		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY		23d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE Raymond R. Ziska				ADDRESS SILVER SPRING, MD.		25a. REC'D BY REGISTRAR NOV 9 '60	
				25b. REGISTRAR'S SIGNATURE Charles S. Thomas			

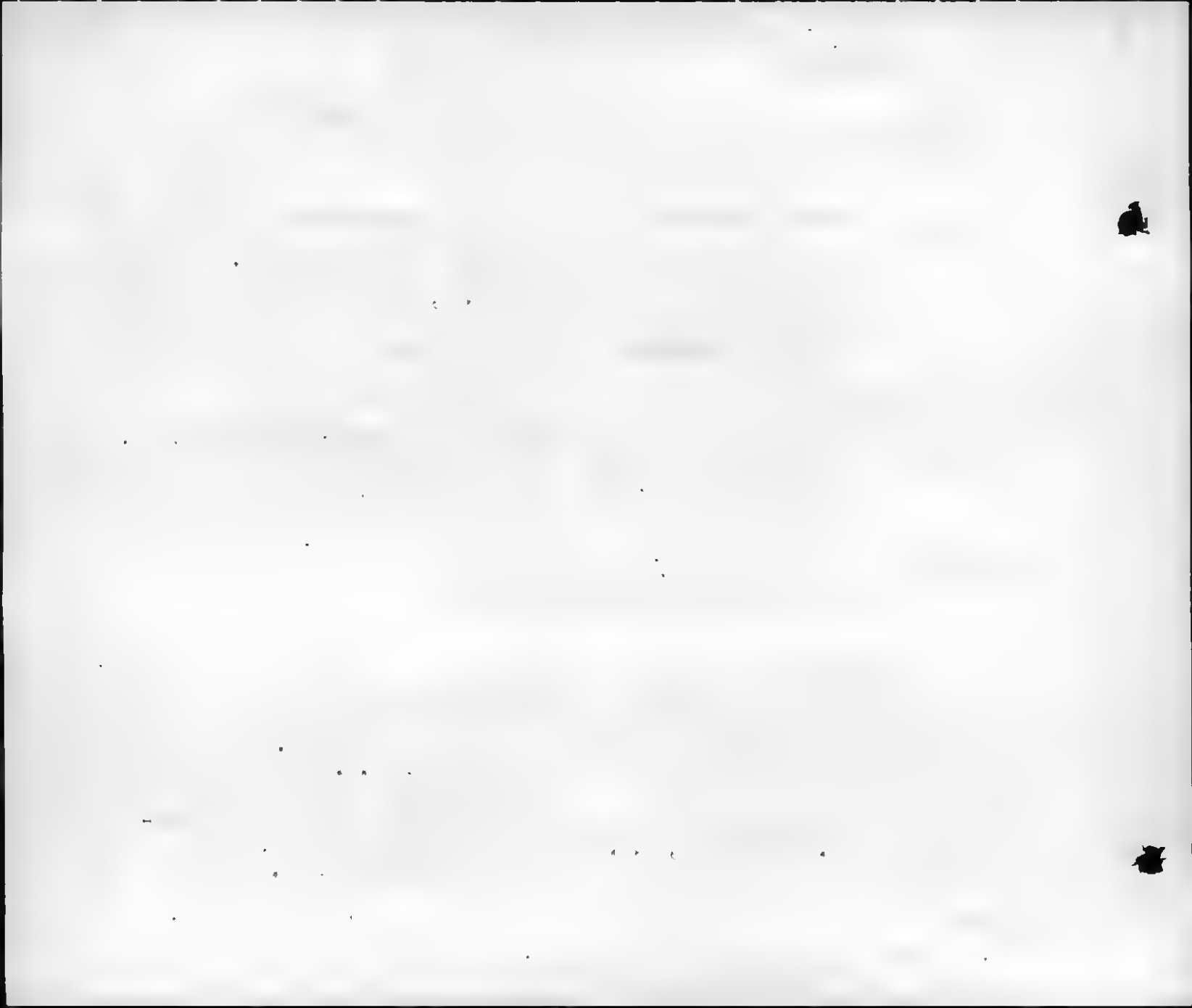


12922

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12916

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 6 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville d. STREET ADDRESS 5312 Crottenden Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Hasel Martin Lloyd				4. DATE OF DEATH Month Day Year Nov. 16 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 1, 1907	
9. AGE (In years last birthday) 53 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Engineer		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME James Lloyd				14. MOTHER'S MAIDEN NAME Lydia Norton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. no			
17. INFORMANT Florence E Lloyd Roger				Address Heights, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myo-cardial infarct DUE TO (b) Cardiac tamponade Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (c) Atherosclerotic Hds - PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) hypertension INTERVAL BETWEEN ONSET AND DEATH 6 day 1 hr several							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from Nov 1st 1960 to Nov. 16 1960 , that (I) (we) last saw the deceased alive on Nov 16th 1960 , and that death occurred at 5:30 A.M. from the causes and on the date stated above							
22a. SIGNATURE Dr. Til Bergman, M.D.							
22b. PHYSICIAN'S NAME (Type) Dr. Til Bergman, M.D.							
22c. ADDRESS 3 D Crescent Road, Green Belt, Md.							
22d. ADDRESS 3 D Crescent Road, Green Belt, Md.							
23a. BURIAL CREMATION, REMOVAL (Specify) Burial							
23b. DATE THEREOF Nov 19, 1960							
23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery							
23d. LOCATION (City, town, or county) (State) Colmar Manor, Md.							
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Maryland.							
25a. REC'D BY REGISTRAR NOV 21 '60							
25b. REGISTRAR'S SIGNATURE William S. Kline							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12917

12923

1 PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
c. LENGTH OF STAY IN 1b 6 hrs. 5 min.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		d. STREET ADDRESS 2202 Cheverly Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First John Middle T. Last Maloney		4. DATE OF DEATH Month Nov Day 3 Year 1960			
5 SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B DATE OF BIRTH January 22, 1895	9 AGE (In years last birthday) 65 yrs	IF UNDER 1 YEAR Months Days Hours Min
10a USJAL OCCUPATION (Give kind of work done during most of working life, even if retired) Medical Doctor		10b. KIND OF BUSINESS OR INDUSTRY Self		11. BIRTHPLACE (State or foreign country) Connecticut	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Edward L. Maloney		14. MOTHER'S MAIDEN NAME Margaret Delaney	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) XXX Yes (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO		17. INFORMANT Address Mrs. Mary L. Maloney (Wife) Same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 443X Inten-cerebral hemorrhage DUE TO (b) Hypertensive Cardiovascular Disease DUE TO (c) Syns Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH 10 hours
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21 I certify that (I) (this hospital) attended the deceased from July 1960 to Nov 3, 1960 , that (I) (we) last saw the deceased alive on Nov 3, 1960 , and that death occurred at 3:50 PM , from the causes and on the date stated above.					
22a SIGNATURE Norman Donat Comeau		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b DATE SIGNED	
22c PHYSICIAN'S NAME (Type) NORMAN DONAT COMEAU		22d ADDRESS 3503 PENNSYLVANIA AVE NW WASHINGTON D.C.			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11/7/60	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet	23d. LOCATION (City, town, or county) (State) Washington D. C.		
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR Nov 9 '60	25b. REGISTRAR'S SIGNATURE Arthur L. Hines



FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1043. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/19

Novo

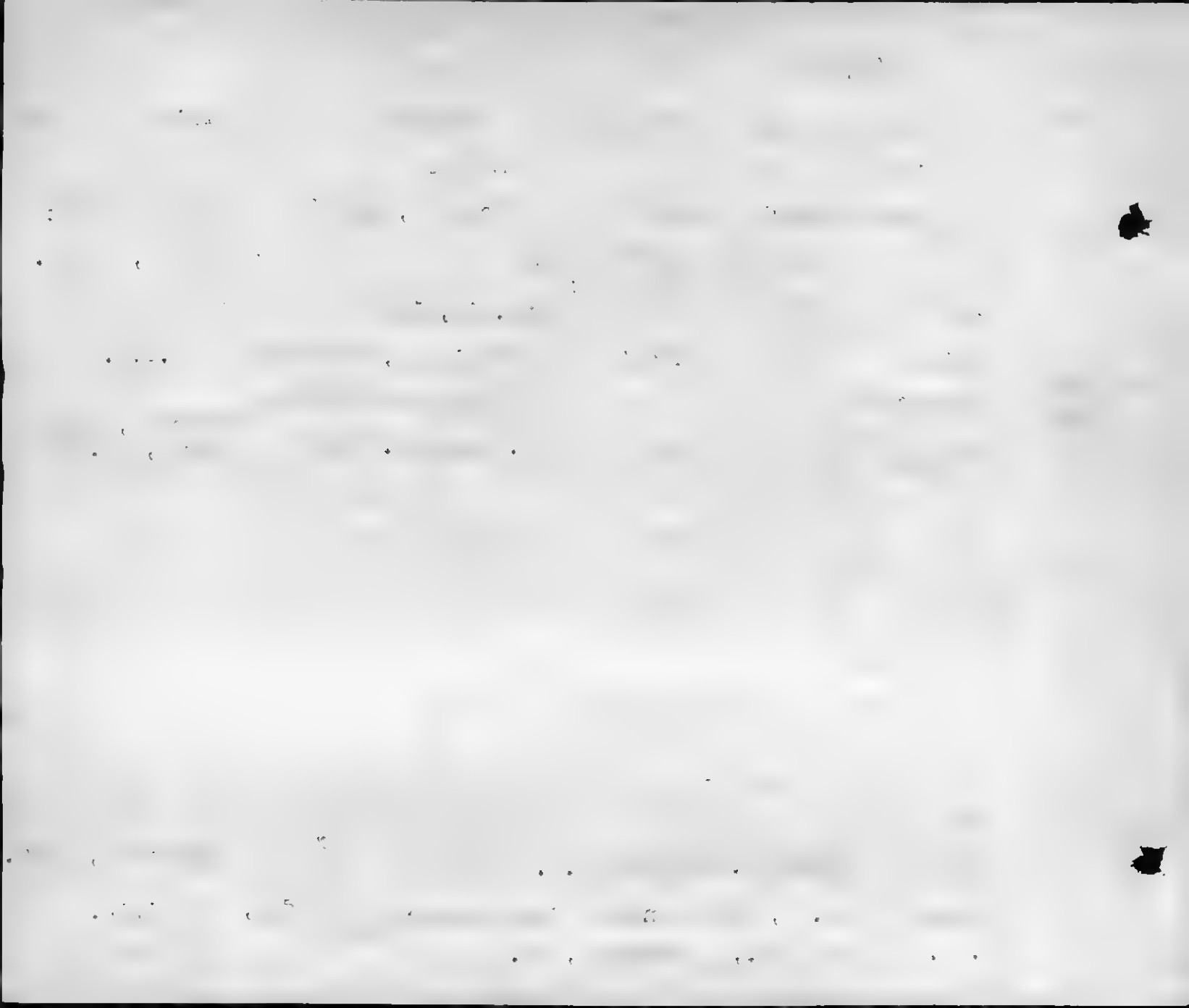
MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12959 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12918

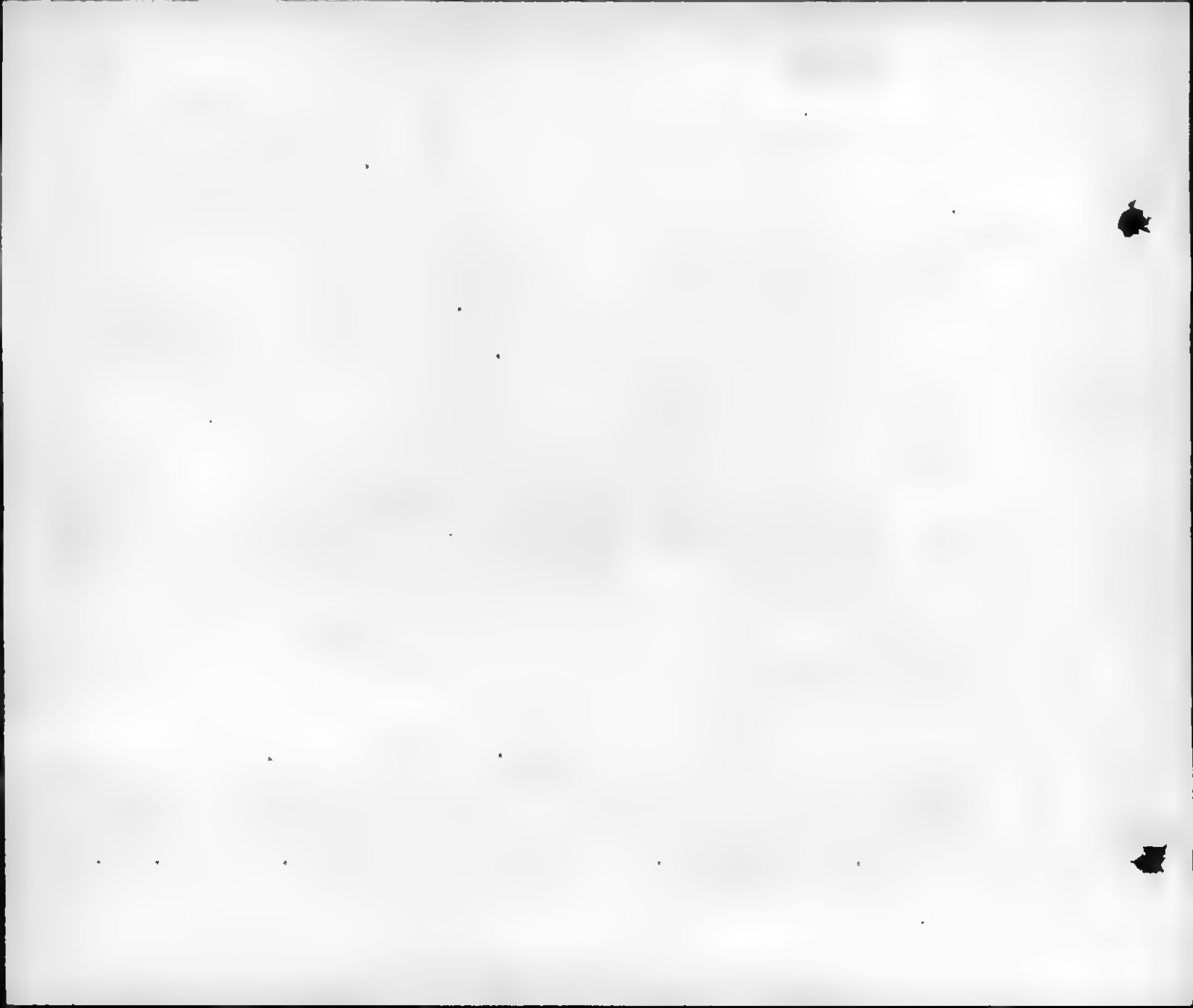
1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Riverdale		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Laurel	
c. LENGTH OF STAY IN b. Leland Memorial Hospital		d. STREET ADDRESS Route 1, Box 63	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) KENNETH WAYNE MANN	Fst Mdlle Last	4. DATE OF DEATH November 24, 1960.	Month Day Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 13, 1960
9. AGE (In years last birthday) 3 yrs.		10. IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY Infant	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Gilmer Mann		14. MOTHER'S MAIDEN NAME Gladys Louise Mabe	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No None None		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Gladys L. Mann		Address Route #1, Box 63 Laurel, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, Hemorrhagic DUE TO (b) Lobular Bilateral DUE TO (c) 2 days. Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Dayton Watkins NAME (Type) DAYTON O. WATKINS, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED November 24, 1960.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 27, 1960	
22c. NAME OF CEMETERY OR CREMATORY Mountain View Cemetery		22d. LOCATION (City, town, or country) (State) Abingdon, Virginia.	
23. FUNERAL DIRECTOR W. W. CHAMBERS CO., Riverdale, Md.		24. BY REGISTRAR NOV 28 1960 DATE 24b. REGISTRAR'S SIGNATURE Arthur S. House	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

<div style="text-align: center;"> CERTIFICATE OF DEATH <div style="display: flex; justify-content: space-between;"> <div> 12924 <div style="text-align: right;">12919</div> </div> <div> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND </div> </div> </div>											
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND						2. USUAL RESIDENCE (Where deceased lived If institution Res dence before adm ssion) a. STATE Maryland b. COUNTY Prince Georges					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 42 Cheverly					
d. NAME OF HOSPITAL (If not in hosp tal, give street address) OR INSTITUTION Prince Georges General Hospital						d. STREET ADDRESS 5823 Dewey Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Stella First M Middle McAvoy Last						4. DATE OF DEATH Month Nov Day 27 Year 19 60					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 16 Apr. 1889		9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) NEAR BOONSBORO WASH. Co. MD. U.S.A.				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM HENRY SMITH						14. MOTHER'S MAIDEN NAME ANNA CLARA FURRY					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)						16. SOCIAL SECURITY NO. 215-20-9935A		17. INFORMANT 5823 DEWEY ST. HORACE McAVOY CHEVERLY MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]											
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Tamponade											
720-1 DUE TO Myocardial Infarction with rupture											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO Thrombosis of Right Coronary Artery											
DUE TO Coronary Arteriosclerotic Heart Disease											
INTERVAL BETWEEN ONSET AND DEATH 4 days 4 days years											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a m. p m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Nov. 23, 1960, to Nov. 26, 1960, that (I) (we) last saw the deceased alive on 26 Nov 1960, and that death occurred at 5:10 AM from the causes and on the date stated above.											
22a. SIGNATURE Francis D. DeCoste, MD.						22b. DATE 11/27/60					
22c. PHYSICIAN'S NAME (Type) Dr. Frances DeCoste., MD						22d. ADDRESS 9608 Underwood St. Seabrook., Md.					
23a. BURIAL, CREMATION OR REMOVAL (Specify) BORIAL				23b. DATE THEREOF NOV. 29. 1960		23c. NAME OF CEMETERY OR CREMATORY BOONSBORO CEMETERY				23d. LOCATION (City, town, or county) (State) BOONSBORO WASH. Co. MD.	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. J. ...						25a. REC'D BY REGISTRAR REC 1 '60					
25b. REGISTRAR'S SIGNATURE C. ...											

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7, P. 11, 1-1-60, at

CERTIFICATE OF DEATH

Reg. Dist. No.

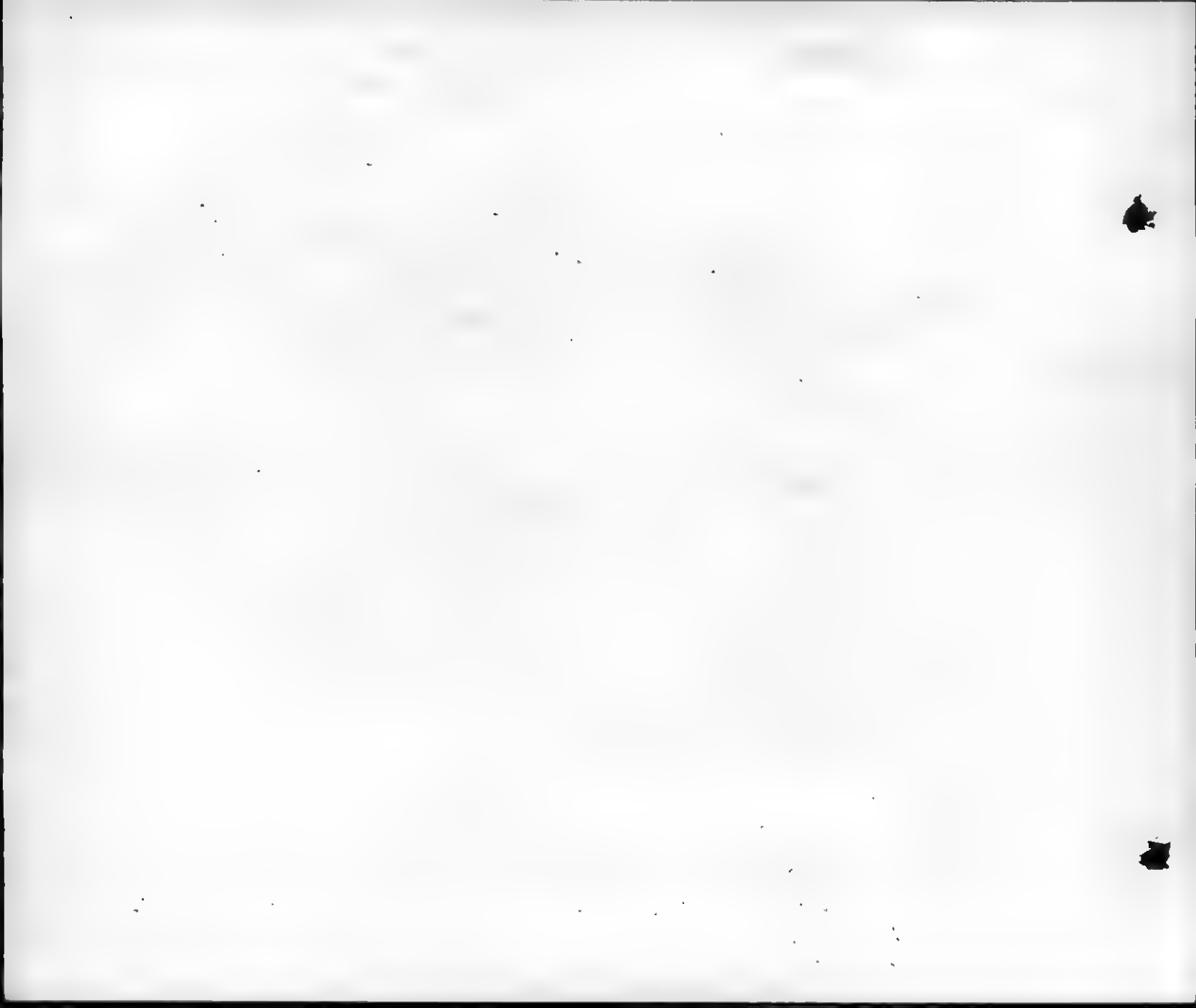
12940

12979

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town.) <u>Brookdale Hgts.</u>				c. LENGTH OF STAY IN 1b <u>6405 - 8 Leavitt Rd.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>Edgewood Hgts. Wf.</u>			
3. NAME OF DECEASED (Type or print) <u>Mary M. B. Beldor</u>				4. DATE OF DEATH Month <u>Nov</u> - Day <u>25</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-28-1914</u>		9. AGE (In years last birthday) <u>46</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min <u>1</u>	
10b. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laundry worker</u>				10c. KIND OF BUSINESS OR INDUSTRY <u>Laundry</u>		11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>unk</u>			
14. MOTHER'S MAIDEN NAME <u>unk</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) <u>no</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>no</u>				INFORMANT <u>Mrs. Mary Robinson</u> Address <u>4409 Shuff</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Heart Disease</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> (c) <u>no</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month <u>11</u> Day <u>24</u> Year <u>1960</u> Hour <u>3:15</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11-24</u> , 19 <u>55</u> to <u>Nov 25</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Nov 25</u> , 19 <u>60</u> , and that death occurred at <u>3:15</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H. C. Beldor</u> M.D. <u>H. H. 2-1 Hunt Pl. NE</u>				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>H. C. Beldor MD Wash. 19 12 19</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-29-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Shirley R. Beldor</u>				ADDRESS <u>4339 Hunt Pl., N.E. Wash. D.C.</u>		24a. REGISTRY REGISTRAR DATE <u>Nov 28 60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Charles S. Frame</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12927

12965

CERTIFICATE OF DEATH

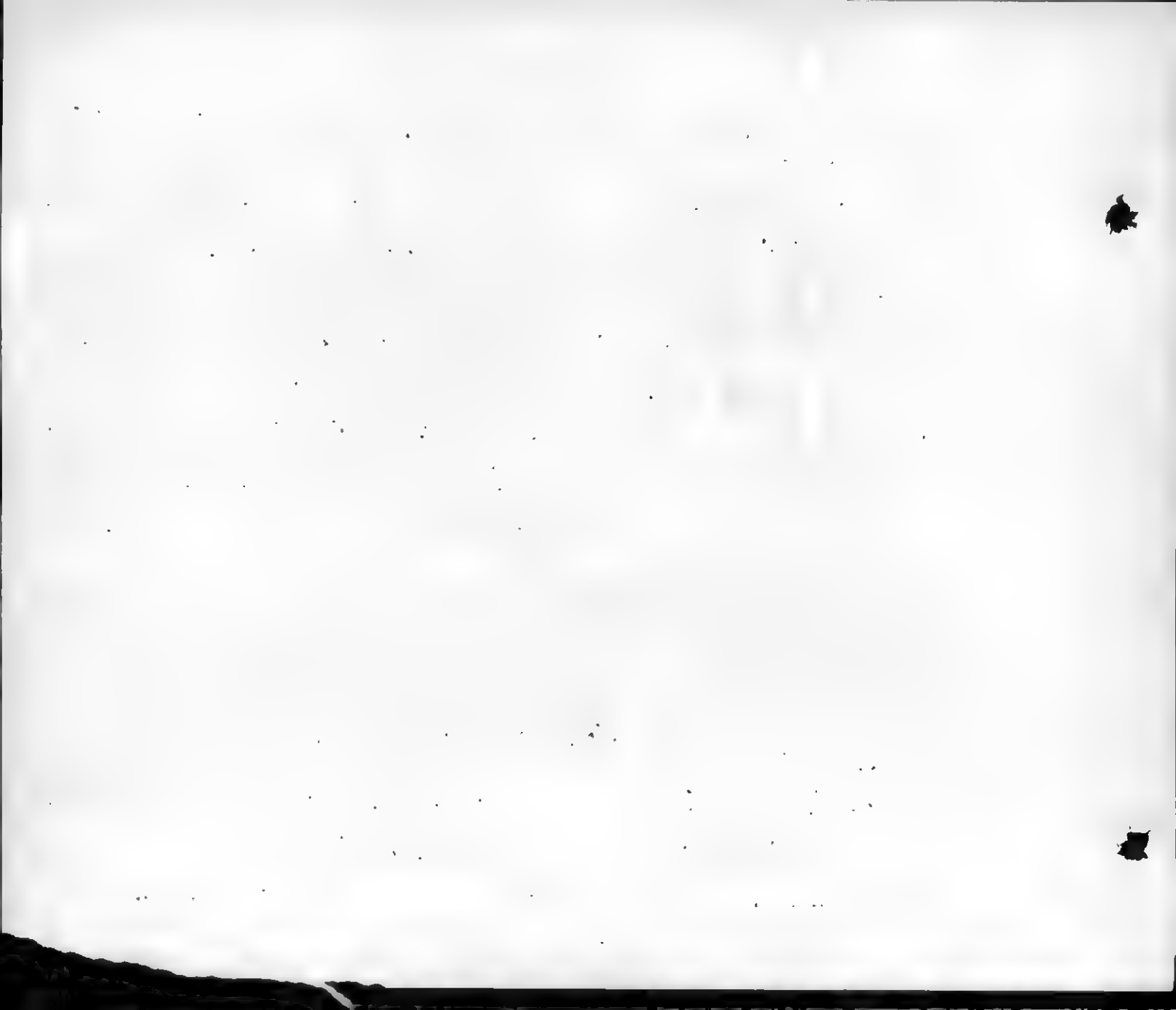
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If inst't on, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges.</u>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Seat Pleasant</u>		c. LENGTH OF STAY IN 1b <u>1 year</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6925 Adel Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>EMMA BERTHA MCGINNIS</u>		4. DATE OF DEATH Month Day Year <u>November 6 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 15, 1871</u>
9. AGE (In years last birthday) <u>89</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>New Orleans, Louisiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM WALDSAUR</u>		14. MOTHER'S MAIDEN NAME <u>VIRGINIA ROUSSE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs. E. Harbach</u>		Address <u>6925 Adel St., Seat Pleasant, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardior-Vascular</u> <u>411.2X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Renal disease</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>15 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept 15, 1940</u> to <u>Nov. 6, 1960</u> that I last saw the deceased alive on <u>November 6, 1960</u> , and that death occurred at <u>6:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William Brainin</u> M.D.		DATE SIGNED <u>11/6/60</u>	
PHYSICIAN'S NAME (Type) <u>WM BRAININ</u>		<u>Capitol Heights Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-9-1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Addison Chapel</u>	22d. LOCATION (City, town, or county) (State) <u>Seat Pleasant, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph David M. Inc. 1766 Pa. Ave. NW</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 9 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hays</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VII A15 (4)
15M 9/58



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and comp. every filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and comp. every filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
ISM 9/59

12960

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1260

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale				c. LENGTH OF STAY IN 1b 12 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Heland Memorial Hospital				e. STREET ADDRESS 1215 Gunpowder Rd			
3. NAME OF DECEASED (Type or print) Hector C McKee				4. DATE OF DEATH Nov. 29 1960			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-7-79	
9. AGE (In years last birthday) 81 yrs		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS Hours Min		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME Benjamin P. McKee				14. MOTHER'S MAIDEN NAME Deana Aitchison			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service.		16. SOCIAL SECURITY NO		17. INFORMANT Address Hospital Record			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarction DUE TO Conditions if any which gave rise to immediate cause (a), stating the underlying cause last (b) Coronary Thrombosis DUE TO (c) Arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension + Cerebral Thrombosis.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 11-17-60 to 11-28-60, that (I) (we) last saw the deceased alive on 11-23-60, and that death occurred at 12 PM, from the causes and on the date stated above.							
22a. SIGNATURE D.R. Purdie				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) D.R. PURDIE				22d. ADDRESS			
23a. BURIAL, CREMATON OR REMOVAL (Specify) Burial		23b. DATE THEREOF 12/2/60		23c. NAME OF CEMETERY OR CREMATORY Ivy Hill Cemetery		23d. LOCATION (City, town, or county) (State) Laurel Md	
24. FUNERAL DIRECTOR'S SIGNATURE				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
1215 Gunpowder Rd, Laurel, Md				DATE DEC 9 '60		C. L. & K. K.	

MEDICAL CERTIFICATION



may be filled by the hospital attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

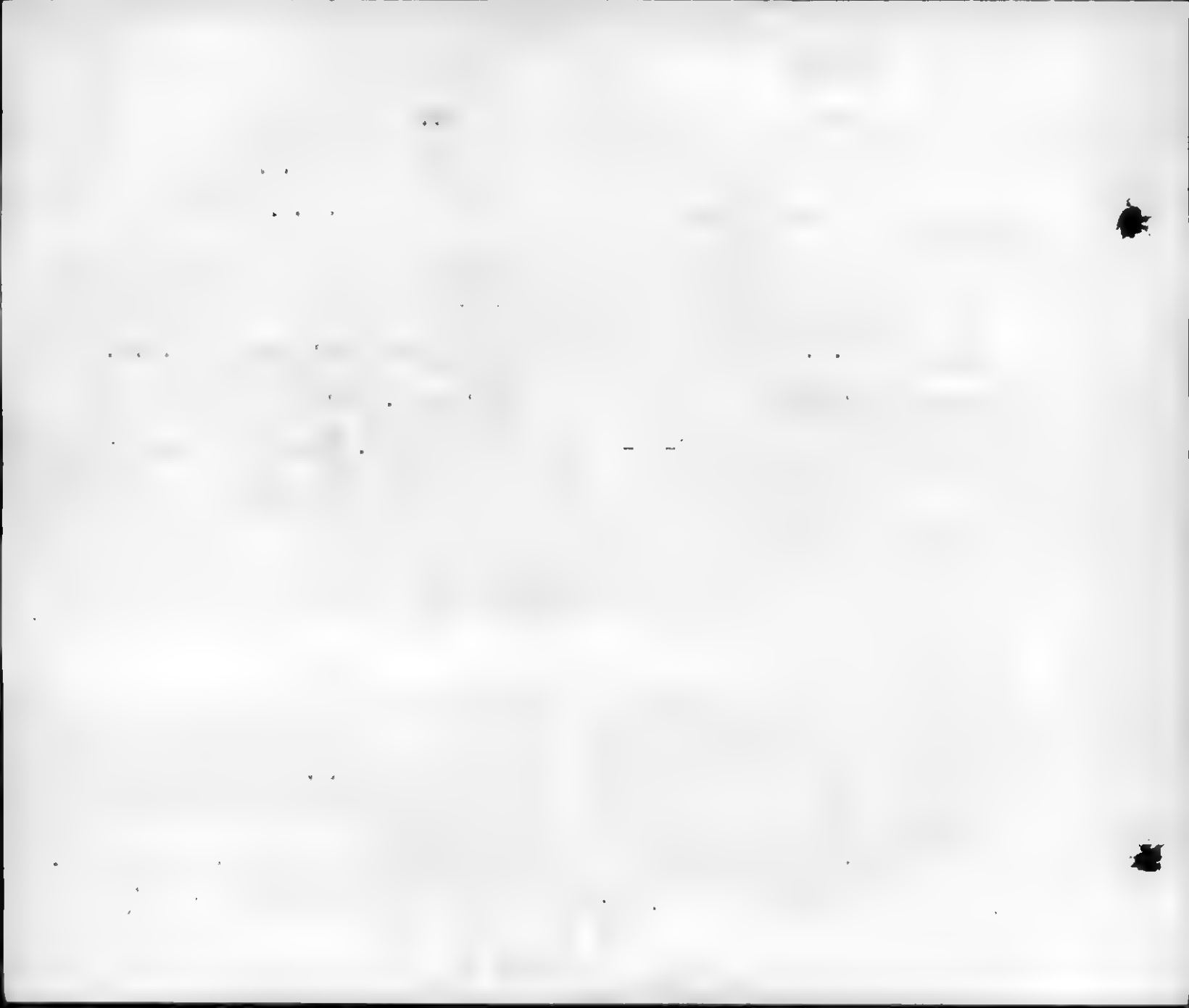
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12925

12922

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 5 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.			
				d. STREET ADDRESS 3004 Perry St. N.E.			
3. NAME OF DECEASED (Type or print) First Middle Last John E Merriken				4. DATE OF DEATH Month Day Year November 9 1960			
5. SEX Male		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-22-81	
9. AGE (In years last birthday) 79 yrs		10. MONTHS 9		11. HOURS 7		12. MINUTES 47	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employee D.C. National Guard				10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Maryland			
11. BIRTHPLACE (State or foreign country) U.S.A.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME George Merriken				14. MOTHER'S MAIDEN NAME Marian V. Ward			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 579-30-7574		17. INFORMANT Wilhelmina T. Merriken (As above)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral vascular accident 443 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive arteriosclerotic heart disease DUE TO (c) Myocardial infarction				INTERVAL BETWEEN ONSET AND DEATH 5 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb 25 1955 to April 1960 that (I) (we) last saw the deceased alive on April 1960 , and that death occurred at 9:45 PM from the causes and on the date stated above.							
22a. SIGNATURE George C. Hageage				22b. DATE SIGNED Nov 9, 1960			
22c. PHYSICIAN'S NAME (Type) Dr. Chas. Hageage				22d. ADDRESS 3308 Perry Street, Mt. Rainier, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/12/1960		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION (City, town, or county) Colmar Manor, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Nalley's Funeral Home				ADDRESS Mt. Rainier, Md.		25a. REC'D BY REGISTRAR DATE NOV 14 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

Enc



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

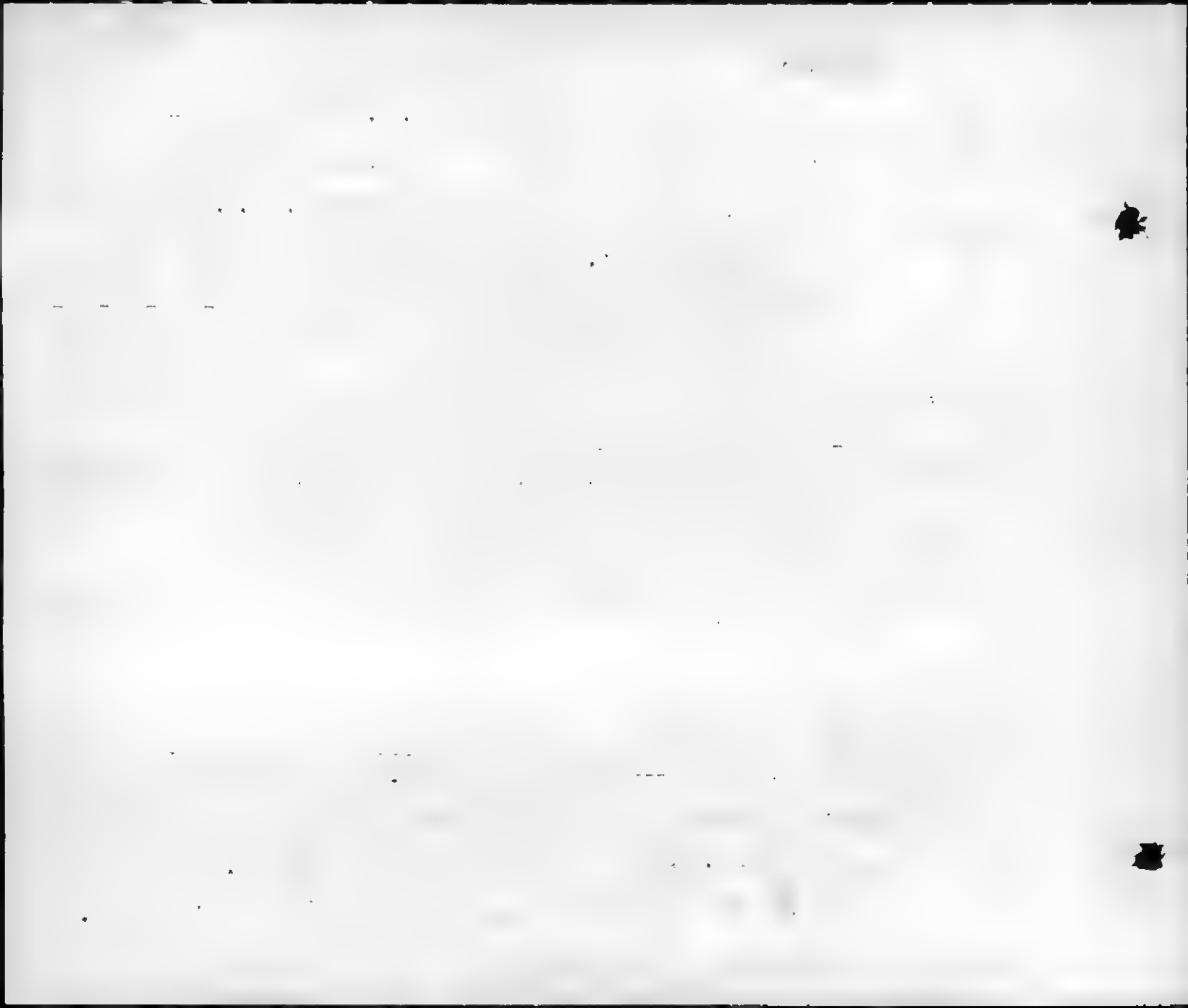
VR A15 (4)
TSM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12980

12943

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived - If institution, Res. dence before admission) a. STATE D. C. b. COUNTY --			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)				c. LENGTH OF STAY IN 1b 7 months and 28 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
				d. STREET ADDRESS 123 49th St., S.E.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Henry Middle O. Last Milburn				4. DATE OF DEATH Month 11 Day 29 Year 19 60			
5 SEX Male		6 COLOR OR RACE Negro		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/24/15	
9 AGE (In years last birthday) 44 yrs		IF UNDER 1 YEAR Months 6 Days -- Hours -- Min --		IF UNDER 24 HRS Hours -- Min --			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Odd jobs			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Samuel Milburn				14. MOTHER'S MAIDEN NAME Aline Gladden			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO Unknown (lost)		17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis, primary site undetermined 177.2 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary tuberculosis, far advanced, active (11 mos.)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from 4/1/1960 to 11/29/60 , that (I) (we) last saw the deceased alive on 11/29/60 , and that death occurred at A. M. from the causes and on the date stated above.							
22a. SIGNATURE Moe Weiss				M. D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M. D.				22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.		22b. DATE SIGNED 11/29/60	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
Burial		12-8-60		St Marks Church Cem.		Valley Lee Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Johnson & Johnson				ADDRESS 4804 Latow. N.W.		25a. REC'D BY REGISTRAR DEC 2 '60	
						25b. REGISTRAR'S SIGNATURE Arthur S. Kneib	



1
FOR STATE
HEALTH DEPT.

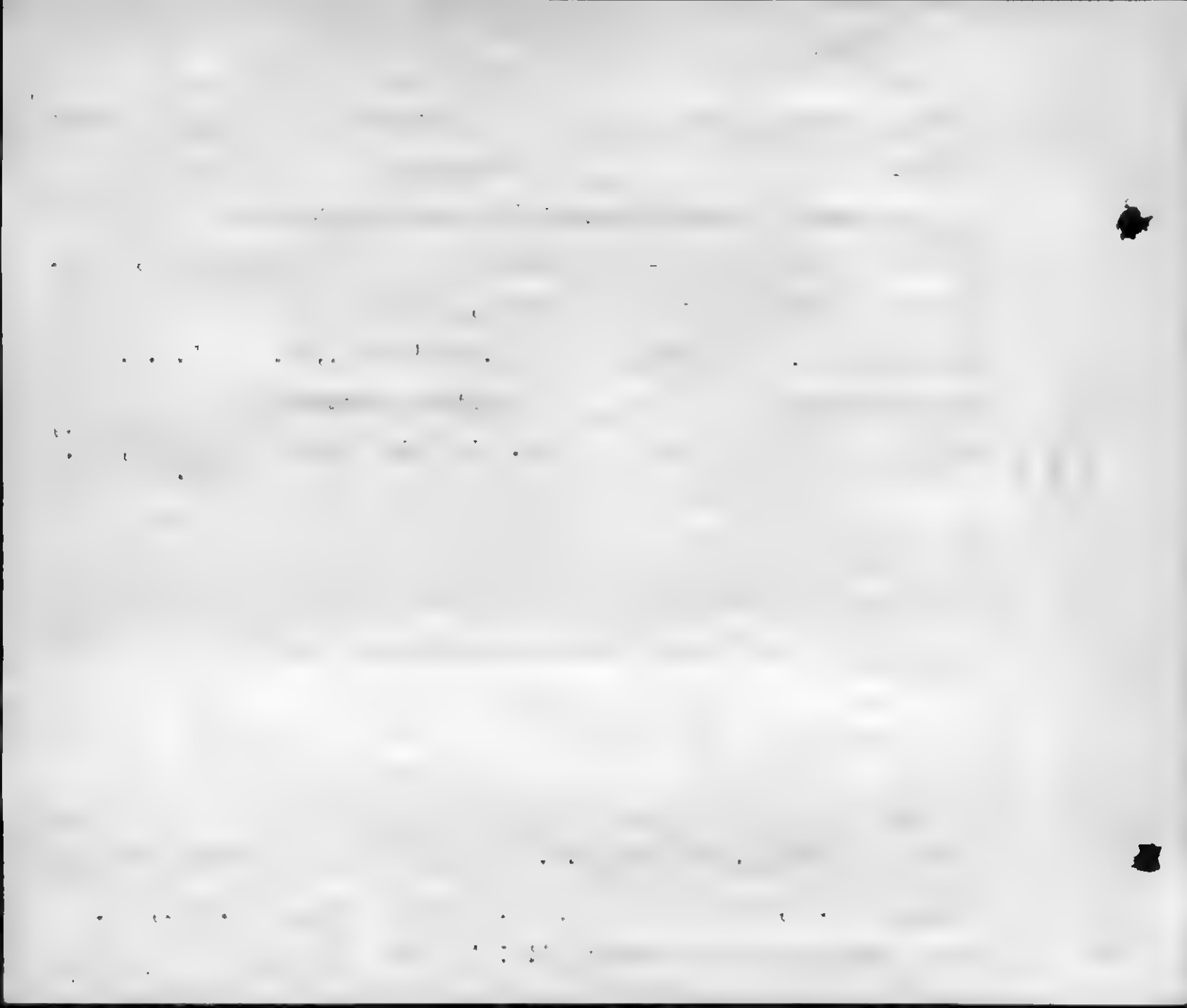
DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a key is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
12926 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12924

1. PLACE OF DEATH a. COUNTY <u>Prince Georges County</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN b. <u>1</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenarden</u> d. STREET ADDRESS <u>5th and Lincoln Avenue</u>			
3. NAME OF DECEASED (Type or print) <u>ELIZABETH CIVILLE MILES</u>		4. DATE OF DEATH <u>November 24, 1960.</u>		5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>May 3, 1876</u>	9. AGE (In years, last birthday) <u>84</u> yrs.	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS Hours <u>0</u> Min. <u>0</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife Ret.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>St. Mary's Cty., Md.</u>			
13. FATHER'S NAME <u>John Statesman</u>		14. MOTHER'S MAIDEN NAME <u>Henrietta Statesman</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Victoria Holmes</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>(pulmonary edema)</u> DUE TO (c) <u>arteriosclerosis generalized</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. <u>30 min</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>2</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Dayton O. Watkins</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED			
EXAMINER'S NAME (Type) <u>DAYTON O. WATKINS, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 29, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Harmony Pk. Cemetery Prince Geo. Cty., Md.</u>			
23. FUNERAL DIRECTOR <u>HENRY WASHINGTON</u>		ADDRESS <u>4927 Deane Ave N.W.C.</u>		24a. REC'D BY REGISTRAR <u>NOV 29 '60</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>							

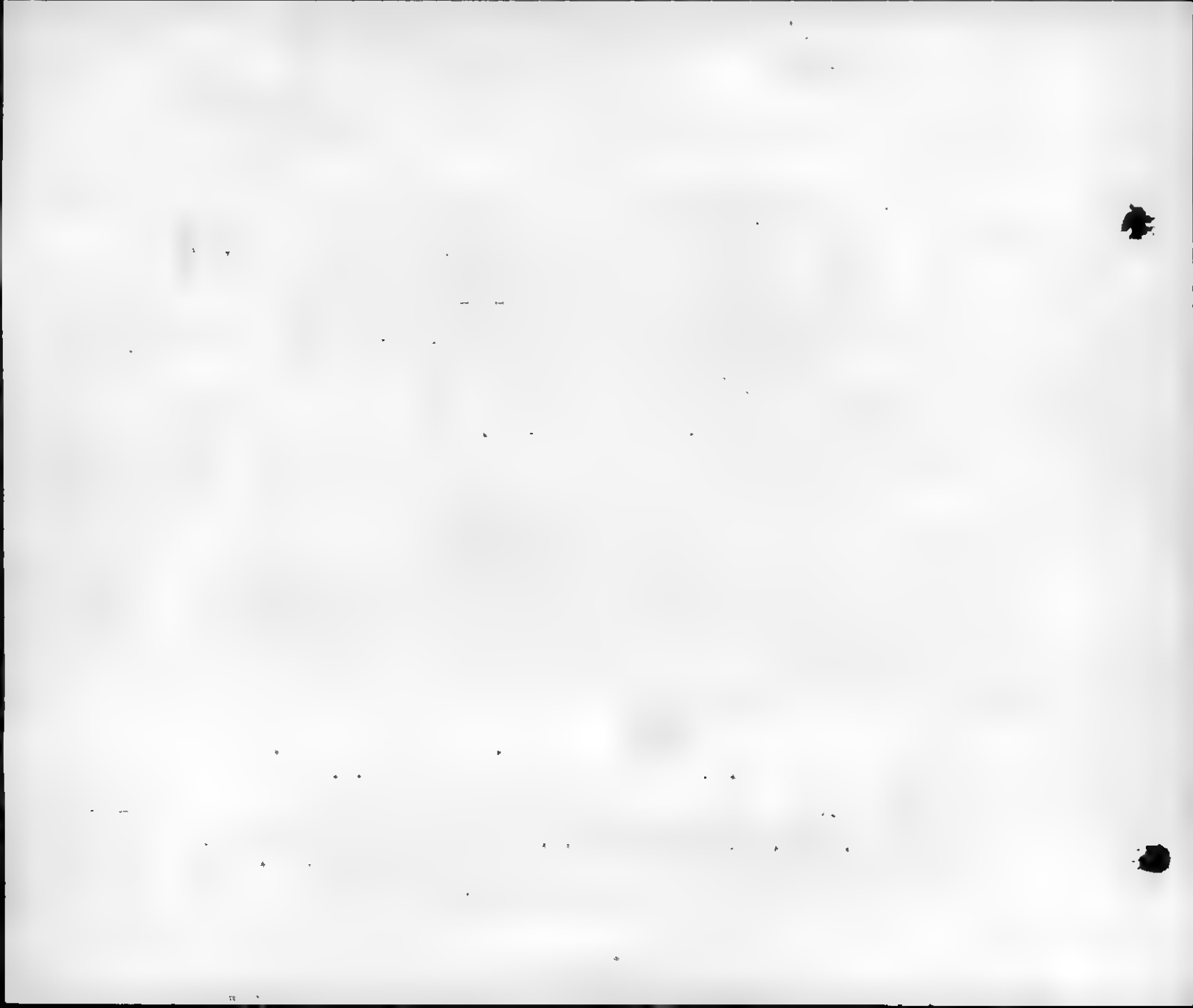


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12927

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12925

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 6 Hr			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Joseph Middle I Last Milstead				4. DATE OF DEATH Month Nov. Day 12 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-12-82	
9. AGE (In years, months, days) 78 yrs.		10. IF UNDER 1 YEAR Months 12 Days 12 Hours 12 Min.		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME TRUMAN MILSTEAD				14. MOTHER'S MAIDEN NAME ANNIE MILSTEAD			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. YES		17. INFORMANT MRS EDNA B. MILSTEAD Address SAME AS #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple Pulmonary Emboli							
420-1 DUE TO							
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last							
(b) Myocardial Fibrosis and Calcification 20 years							
(c) Chronic Adhesive Pericarditis 10 years							
(d) Coronary Arteriosclerotic Heart Disease 20 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hydrocephalus (cause undetermined)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Nov. 12, 1960 to Nov. 12, 1960 , that (I) (we) last saw the deceased alive on Nov. 12, 1960 and that death occurred at 5:30 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Dr. Chas. David Connors, M.D. M.D.				22b. ADDRESS 4813 Landover Road, Cheverly, Md.			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11-16-1960		23c. NAME OF CEMETERY OR CREMATORY GEORGE WASHINGTON MEMORIAL		23d. LOCATION (City, town, or county) (State) HYATTSVILLE, MD	
24. FUNERAL DIRECTOR'S SIGNATURE Charles L. Kline				25a. REC'D BY REGISTRAR NOV 18 '60			
25b. REGISTRAR'S SIGNATURE Charles L. Kline				25c. REGISTRAR'S SIGNATURE			

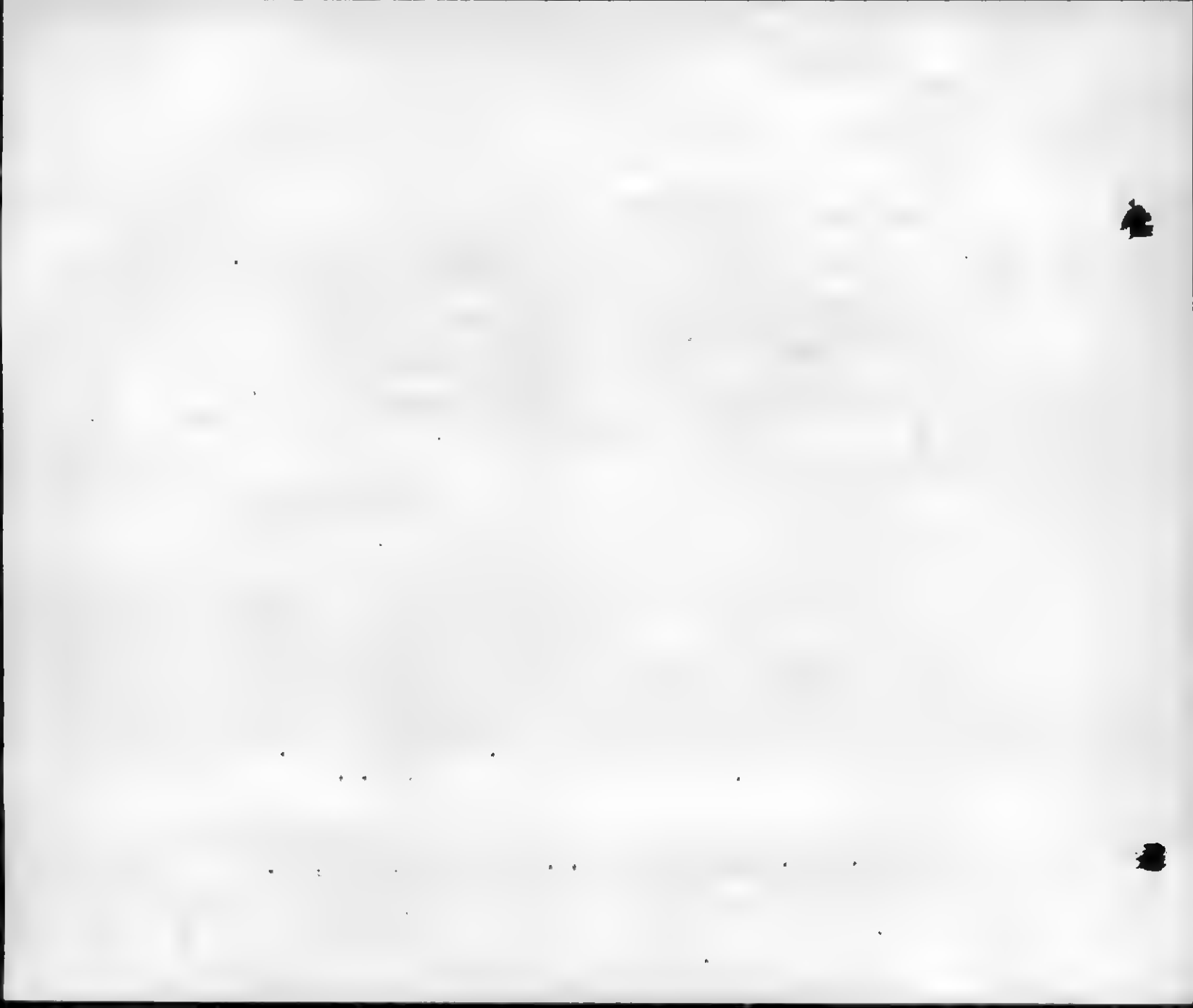


DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12928

12926

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 2 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt Rainier d. STREET ADDRESS 1101 28 th Place e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) John First Nakshian Middle Nakshian Last Nakshian				4. DATE OF DEATH Nov. 21 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3	
9. AGE (In years last birthday) 80		10. IF UNDER 1 YEAR Months 80 Days 80		11. IF UNDER 24 HRS Hours 80 Min 80			
10a. USUAL OCCUPATION (Give kind of work done, during most of working life, even if retired) Machinist				10b. KIND OF BUSINESS OR INDUSTRY Battery Manufacturing		11. BIRTHPLACE (State or foreign country) Germany	
12. CITIZEN OF WHAT COUNTRY? German							
13. FATHER'S NAME W. J. Nakshian				14. MOTHER'S MAIDEN NAME W. J. Nakshian			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no				16. SOCIAL SECURITY NO 294-03-3015		17. INFORMANT Mrs. Alice Nakshian Address Same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema DUE TO (b) Arterio sclerotic Ht dis. Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (c) Arterio sclerotic Ht dis.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arterio sclerotic Ht dis.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov. 19 1960 , to Nov. 21 1960 , that (I) (we) last saw the deceased alive on Nov. 21 1960 , and that death occurred at 1:45 PM the causes and on the date stated above							
22a. SIGNATURE Dr. Chas. David Connors, M.D.				22b. DATE SIGNED Nov. 21 1960			
22c. PHYSICIAN'S NAME (Type) Dr. Chas. David Connors, M.D.				22d. ADDRESS 5813 Landover Road, Cheverly, Md.			
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 11-23-1960		23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		23d. LOCATION (City, town, or county) (State) Washington, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Kraus				25a. REC'D BY REGISTRAR NOV 28 1960		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

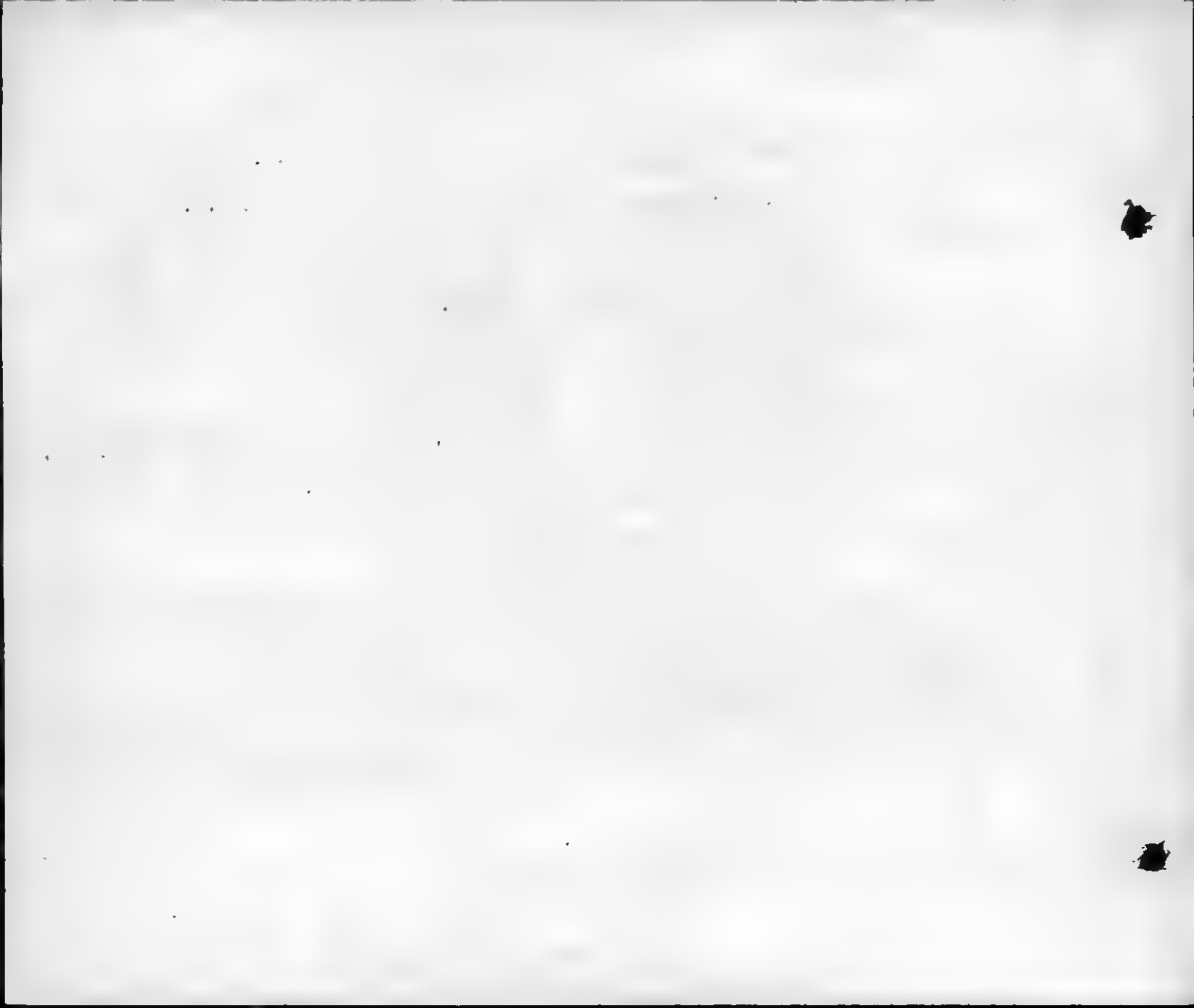


12929

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12927

1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE MARYLAND b. COUNTY Washington D.C.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesley				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington D.C.			
c. LENGTH OF STAY IN 1b 4 days				d. STREET ADDRESS 1413 Buchanan St. N.W.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) Albert First Nemer Middle Nemer Last				4. DATE OF DEATH Month Nov Day 19 Year 1960			
5 SEX Male		6 COLOR OR RACE White		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 21 Mar. 1900	
9 AGE (In years last birthday) 60 yrs		10a USJA. OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Syria	
12 CITIZEN OF WHAT COUNTRY? Syria ✓		13. FATHER'S NAME Farrah Nemer		14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	
16 SOCIAL SECURITY NO		17 INFORMANT Robert W. McCormick Address 801 Somerset Place Hyattsville, Md.		18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Infarction 420 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)		21 I certify that (I) (this hospital) attended the deceased from Nov. 14 19 60 to 19 Nov. 19 19 60 that (I) (we) last saw the deceased alive on 19 Nov 19 60 , and that death occurred on 19 Nov 19 60 from the causes and on the date stated above.	
22a SIGNATURE Charles C. Haggard M.D.		22b. DATE SIGNED		22c PHYSICIAN'S NAME (Type) Charles C. Haggard M.D.		22d. ADDRESS 3717 38th Avenue, Cottage City, Maryland	
23a. BURIAL CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 11/21/60		23c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		23d. LOCATION (City, town, or county) (State) Washington, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.		ADDRESS 2901-15th St. N.W.		25a. REC'D BY REGISTRAR DATE NOV 21 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12981

CERTIFICATE OF DEATH

Reg. Dist. No. 12928

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Washington D.C.</u> b. COUNTY <u>4-18</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forest Hills</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>24th Ave.</u>		d. STREET ADDRESS <u>1101 New Hampshire Ave. N.W.</u>	

3. NAME OF DECEASED (Type or print) <u>Della</u> First <u>O'Neill</u> Middle <u>Donohue</u> Last		4. DATE OF DEATH <u>11-24-1960</u> Month <u>11</u> Day <u>24</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1881</u> 79 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gov't</u>	9. AGE (In years last birthday) <u>79</u>
11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	

13. FATHER'S NAME <u>Thomas</u>	14. MOTHER'S MAIDEN NAME <u>Della Donohue</u>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u>171-11-1111</u>
17. INFORMANT <u>RUTH YOUNG</u> Address <u>5909 24th Ave. Hill Crst</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Embolism</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive ASHC</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH
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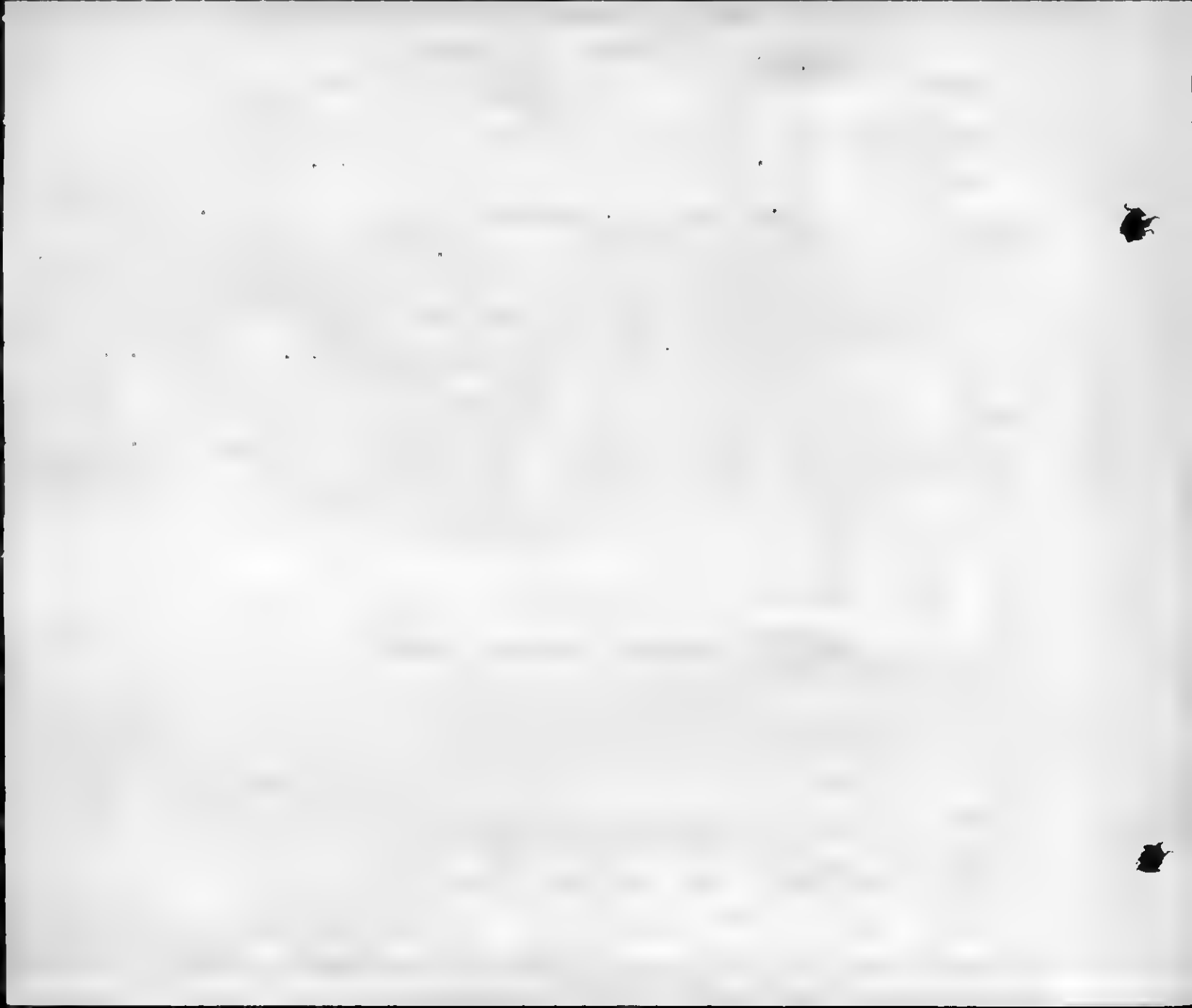
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from <u>11/23, 1960</u> , to <u>11/24, 1960</u> , that I last saw the deceased alive on <u>11/23, 1960</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>David Lena</u> M.D. <u>2301 First Lane SE</u> <u>11/26/60</u>	DATE SIGNED
PHYSICIAN'S NAME (Type) <u>David Lena</u>	

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>11-28-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET</u>	22d. LOCATION (City, town, or county) (State) <u>WASH. D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Timothy Haulon</u> ADDRESS <u>WASH. D.C.</u>		24a. REC'D. BY REGISTRAR <u>NOV 29 60</u> DATE	24b. REGISTRAR'S SIGNATURE <u>William S. Frank</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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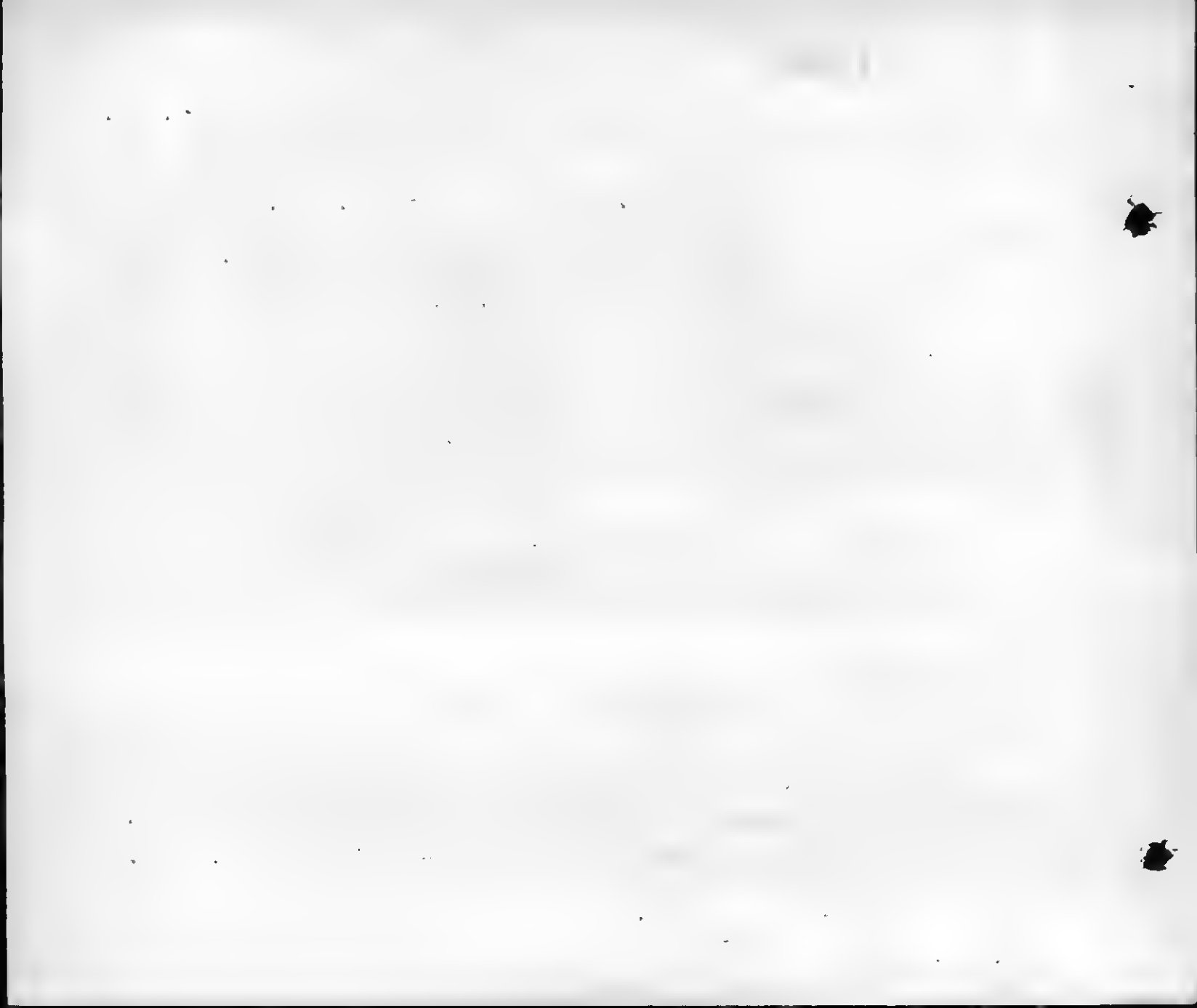
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12982

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12929

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxon Hill				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxon Hill			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1398 Owens Rd S.E.				d. STREET ADDRESS 1398 Owens Rd., S.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ANNIE Middle E Last OWENS				4. DATE OF DEATH Month Nov. Day 26 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 19, 1864	
9. AGE (In years last birthday) 96 yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Richard Moore				14. MOTHER'S MAIDEN NAME Margaret Farr			
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Beatrice O. Eno Address 2100-A 38th St., SE Washington DC	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>432.1</u> <u>BRONCHOPNEUMONIA</u> DUE TO							
(b) <u>Cerebral Vascular Accident</u> DUE TO							
(c) <u>arteriosclerotic Cardiovascular Disease</u> DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>2 days</u> INTERVAL BETWEEN ONSET AND DEATH							
(b) <u>1 month</u>							
(c) <u>20 years</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>July 1955</u> to <u>Nov 26 1960</u> , that (I) was last saw the deceased alive on <u>Nov 26 1960</u> , and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Robert A. Dornbach</u> M.D. ATTENDING PHYS. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> Nov. 26 1960							
22c. PHYSICIAN'S NAME (Type) Robert A. Dornbach 22d. ADDRESS 4221—South Capitol St., Wash. DC							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial							
23b. DATE THEREOF 11-29-60							
23c. NAME OF CEMETERY OR CREMATORY St. Barnabas Cemetery							
23d. LOCATION (City, town, or county) Oxon Hill Maryland (State)							
24. FUNERAL DIRECTOR'S SIGNATURE <u>Demetrius Bus</u> ADDRESS 1661—Good Hope Rd SE Wash. 20 DC							
25a. REC'D BY REGISTRAR NOV 29 '60							
25b. REGISTRAR'S SIGNATURE <u>William S. Funder</u>							



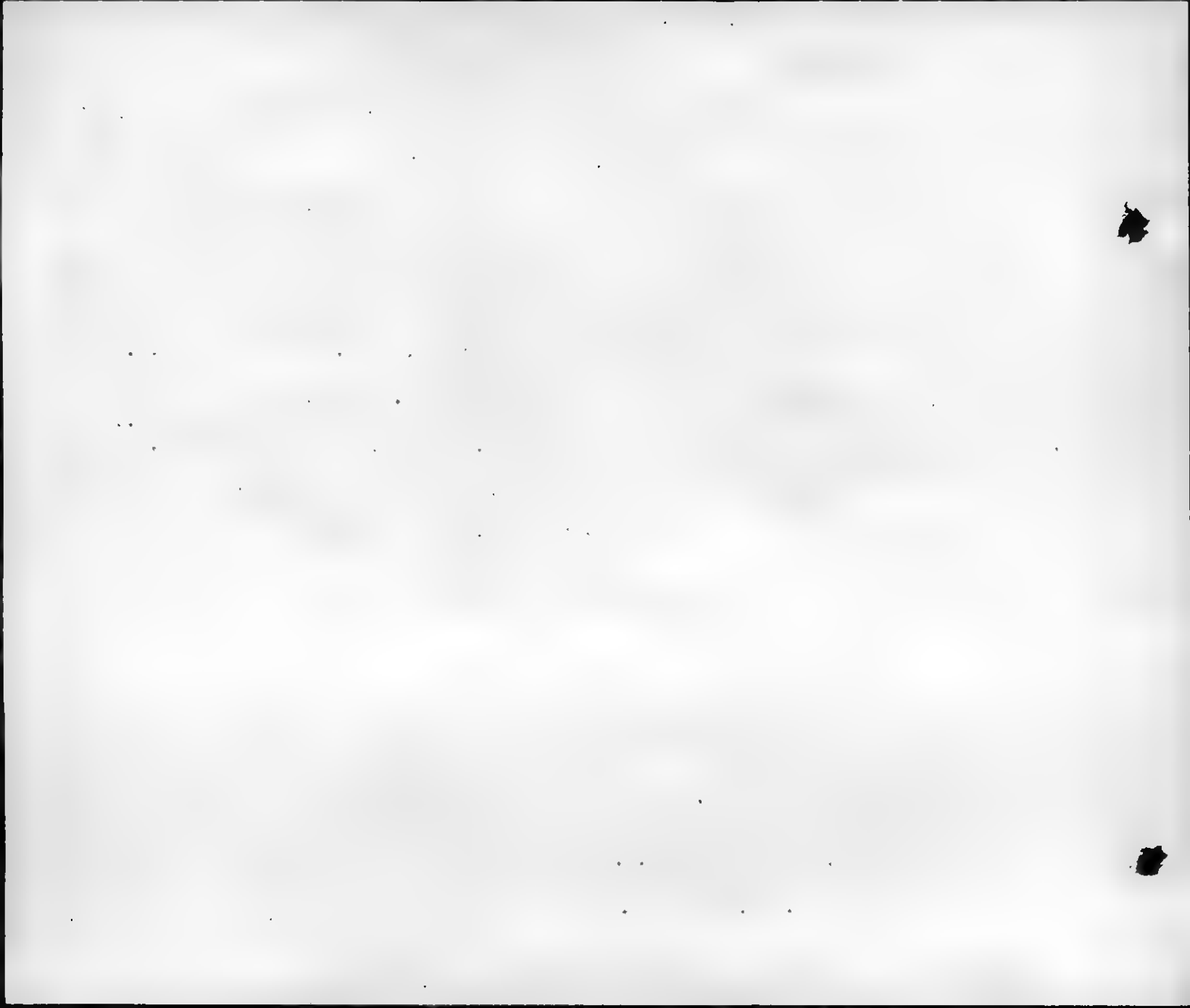
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12930

12930

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 11 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF (Type or print) First Middle Last Stella Parrish				4. DATE OF DEATH Month Day Year Nov 27 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 28 Nov 1891	9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Cresson, Penn.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME David Sheehan				14. MOTHER'S MAIDEN NAME Lucy E. Lipton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT John N. Parrish, Hyattsville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 175.0 CARCINOMATOSIS (Generalized) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ovarian Carcinoma (c)						INTERVAL BETWEEN ONSET AND DEATH 2 years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11-16-1960 to 11-27-1960, that (I) (we) last saw the deceased alive on 11-26-1960, and that death occurred on 11-27-1960 from the causes and on the date stated above.							
22a. SIGNATURE OF PHYSICIAN Dr. Albert Roth M.D.				22b. DATE SIGNED 11/28/60			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL CREMATION (Specify) Burial		23b. DATE THEREOF Nov. 20, 1960		23c. NAME OF CEMETERY OR CREMATORY St. Aloysius Cemetery		23d. LOCATION (City, town, or county) (State) Cresson Pa	
24. FUNERAL DIRECTOR'S SIGNATURE				25a. REC'D BY REGISTRAR DATE NOV 29 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Thomas	



CERTIFICATE OF DEATH

Reg. Dist. No.

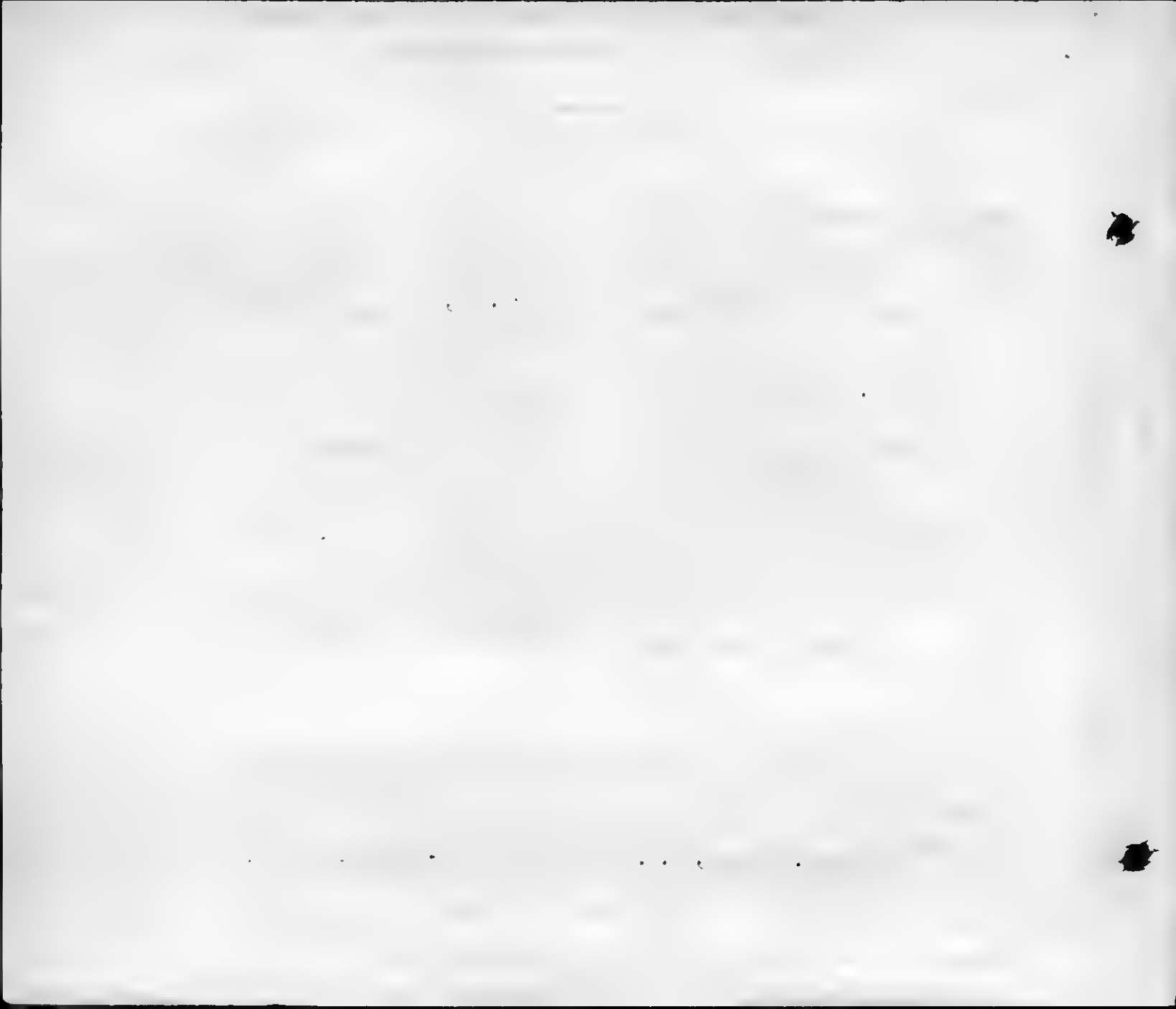
12951

12954

1 PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel c. LENGTH OF STAY IN 1b Laurel General Hospital		2 USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE Maryland b. COUNTY Howard c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Savage d. STREET ADDRESS 601 Washington Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Mary Elizabeth Paul		4. DATE OF DEATH Month Day Year November 11 1960	
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 30, 1896
9. AGE (In years last birthday) 64 yrs		10. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY same	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward F. Condon		14. MOTHER'S MAIDEN NAME Sarah Jane West	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Arteriosclerosis DUE TO Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 3 days 10 yrs 15 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/7 , 19 62 , to 11/11 , 19 60 , that I last saw the deceased alive on 11/11 , 19 60 , and that death occurred at 7:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE J M Warren M.D.			
PHYSICIAN'S NAME (Type) John M. Warren, M.D. 305 Prince George Street, Laurel, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/14/60	22c. NAME OF CEMETERY OR CREMATORY Savage Cem	22d. LOCATION (City, town, or county) (State) Savage, Md
23. FUNERAL DIRECTOR'S SIGNATURE John C. Allen		24. REC'D BY REGISTRAR DATE NOV 16 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



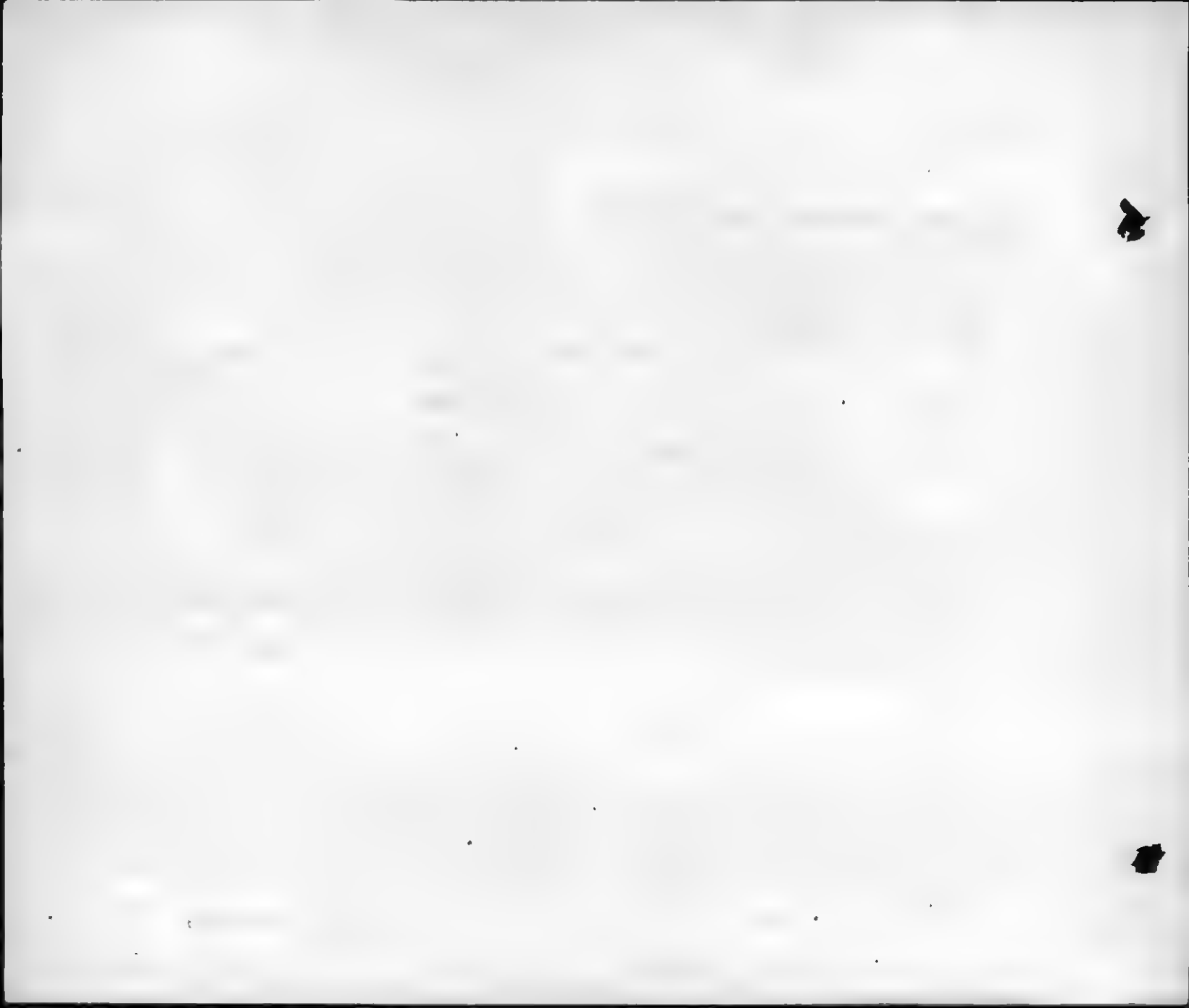
may be examined by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12961

12932

1. PLACE OF DEATH a. COUNTY <u>Prince George, Riverdale</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bladensburg, Md</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eugene Leland Memorial</u>				d. STREET ADDRESS <u>5101 Tilden Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ruth</u> First <u>ROSA</u> Middle <u>Perell</u> Last		4. DATE OF DEATH Month <u>11</u> Day <u>23</u> Year <u>1960</u>					
5 SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5- -1886</u>	9 AGE (In years last birthday) <u>74</u> yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11 BIRTHPLACE (State or foreign country) <u>Argentina, So America</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph ?</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>James J. Perell and same as above.</u> Address			
18. CAUSE OF DEATH [Enter any one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: <u>420.0</u> IMMEDIATE CAUSE (a) <u>Heart coronary thrombosis</u> DUE TO <u>arterio sclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>5 yrs.</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>deaths</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>Nov 22, 1960</u> , to <u>Nov 23, 1960</u> that (I) (we) last saw the deceased alive on <u>Nov 23, 1960</u> and that death occurred at <u>2 p.m.</u> from the causes and on the date stated above							
22a. SIGNATURE <u>L W Malin</u> M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>11-23-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>L W Malin M.D.</u>				22d. ADDRESS <u>Riverdale, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov. 26, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Bladensburg, Maryland.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W W Chong ben Co</u> ADDRESS <u>5801 Cleveland Ave</u>				25a. RECEIVED BY REGISTRAR <u>NOV 28 '60</u> DATE		25b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12983

12983

1. PLACE OF DEATH a. COUNTY <u>Prince George's Maryland</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Danville</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Danville</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mattie</u> Middle <u>M.</u> Last <u>Pinkney</u>				4. DATE OF DEATH Month <u>November</u> Day <u>7</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 25-1921</u>	9. AGE (In years last birthday) <u>38</u> yrs	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Burrough</u>				14. MOTHER'S MAIDEN NAME <u>Cora Johnson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO		17. INFORMANT Address <u>Herbert Pinkney - Danville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>171x</u> DUE TO <u>Arteriosclerosis (Hypertension)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>Coronary Artery Disease</u> (c) <u>Coronary Artery Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10-5-1957</u> to <u>11-7-1960</u> ; that (I) (we) last saw the deceased alive on <u>11-7-1960</u> and that death occurred at <u>4:15 P.M.</u> from the causes and on the date stated above							
22a. SIGNATURE <u>Richard H. Dobson</u>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>Richard H. Dobson</u>				22d. ADDRESS <u>Danville, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>Nov. 10/1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gibbons Church</u>		23d. LOCATION (City, town, or county) (State) <u>Brandywine, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>George G. Nelson</u>				25a. REC'D BY REGISTRAR <u>NOV 10 '60</u>		25b. REGISTRAR'S SIGNATURE <u>C. E. King & Kneass</u>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose a certificate of the medical examiner, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12931

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12904

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Md		c. LENGTH OF STAY IN 1b D O A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro Md		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				d. STREET ADDRESS R F D Box 1460			
3. NAME OF DECEASED (Type or print) First Charles Middle Renzie Last Proctor				4. DATE OF DEATH Month November Day 8 Year 19 60-			
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 2, 1910	9. AGE (In years last birthday) 50 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Robert Proctor				14. MOTHER'S MAIDEN NAME Rosetta Proctor			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Address Elizabeth Dorothy Proctor Upper Marlboro Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 44 3X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive Heart failure (c) Hypertensive Cardiovascular disease							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Dayton O. Watkins EXAMINER'S NAME (Type) Dayton O. Watkins				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED Nov 8, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-11-60		22c. NAME OF CEMETERY OR CREMATORY Church Cemetery		22d. LOCATION (City, town, or county) (State) Oxon Hill Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John T. Rhine Co.				ADDRESS 3015-12th St. N.E. D.C.		24a. REC'D BY REGISTRAR DATE NOV 14 '60	
				24b. REGISTRAR'S SIGNATURE Christina S. Frank			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

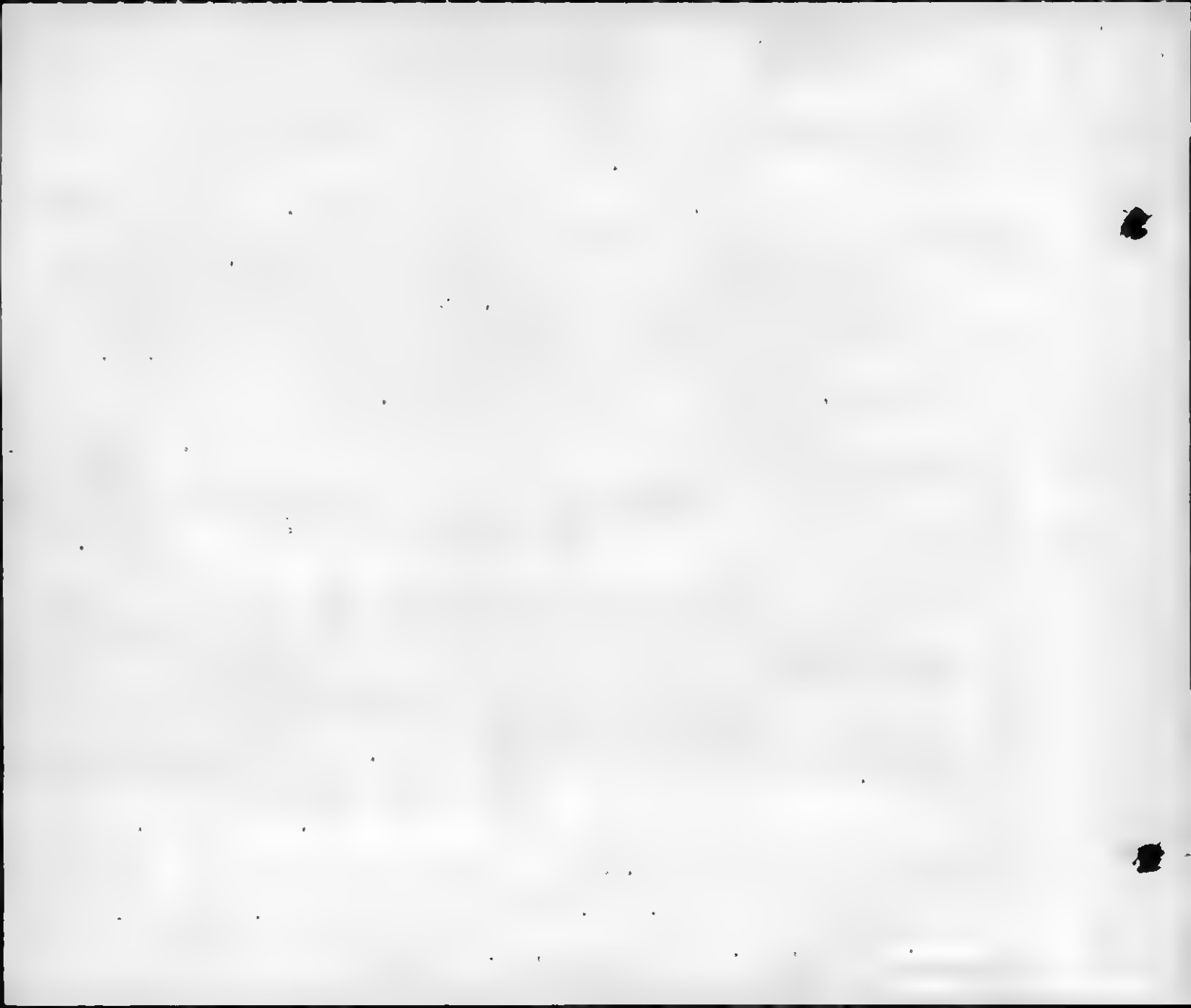
12984 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH

Reg. Dist. No.

12955

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Adelphi</u>				c. LENGTH OF STAY IN 1b <u>5 mos.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Adelphi</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>10,100 Vireo St.</u>				d. STREET ADDRESS <u>10, 100 Vireo St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lela</u> Middle <u>Etelle</u> Last <u>Proffer</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>12</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 30, 1906</u>	
9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Education</u>		11. BIRTHPLACE (State or foreign country) <u>Missouri</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>George W. Proffer</u>				14. MOTHER'S MAIDEN NAME <u>Shirley E. Hampton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>119-32-6005</u>		17. INFORMANT <u>Ila Proffer</u> Address <u>10,100 Vireo St., Adelphi, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1-3-2</u> <u>Inanition</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Descending Colon</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>11 days</u> <u>4 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u>60</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 1, 1960</u> , to <u>Aug. 12, 1960</u> , that I last saw the deceased alive on <u>Aug. 10, 1960</u> , and that death occurred at <u>4:50 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Clairine R. Christman</u> M.D.				ADDRESS (Street, city or town, state) <u>2703 14th St., Adelphi, Md.</u> DATE SIGNED <u>11-21-60</u>			
PHYSICIAN'S NAME (Type) <u>Clairine A. Christman, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/14/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GEO. WASH. CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEORGE COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. S. B. ... INC.</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 17 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kenna</u>			

MEDICAL CERTIFICATION

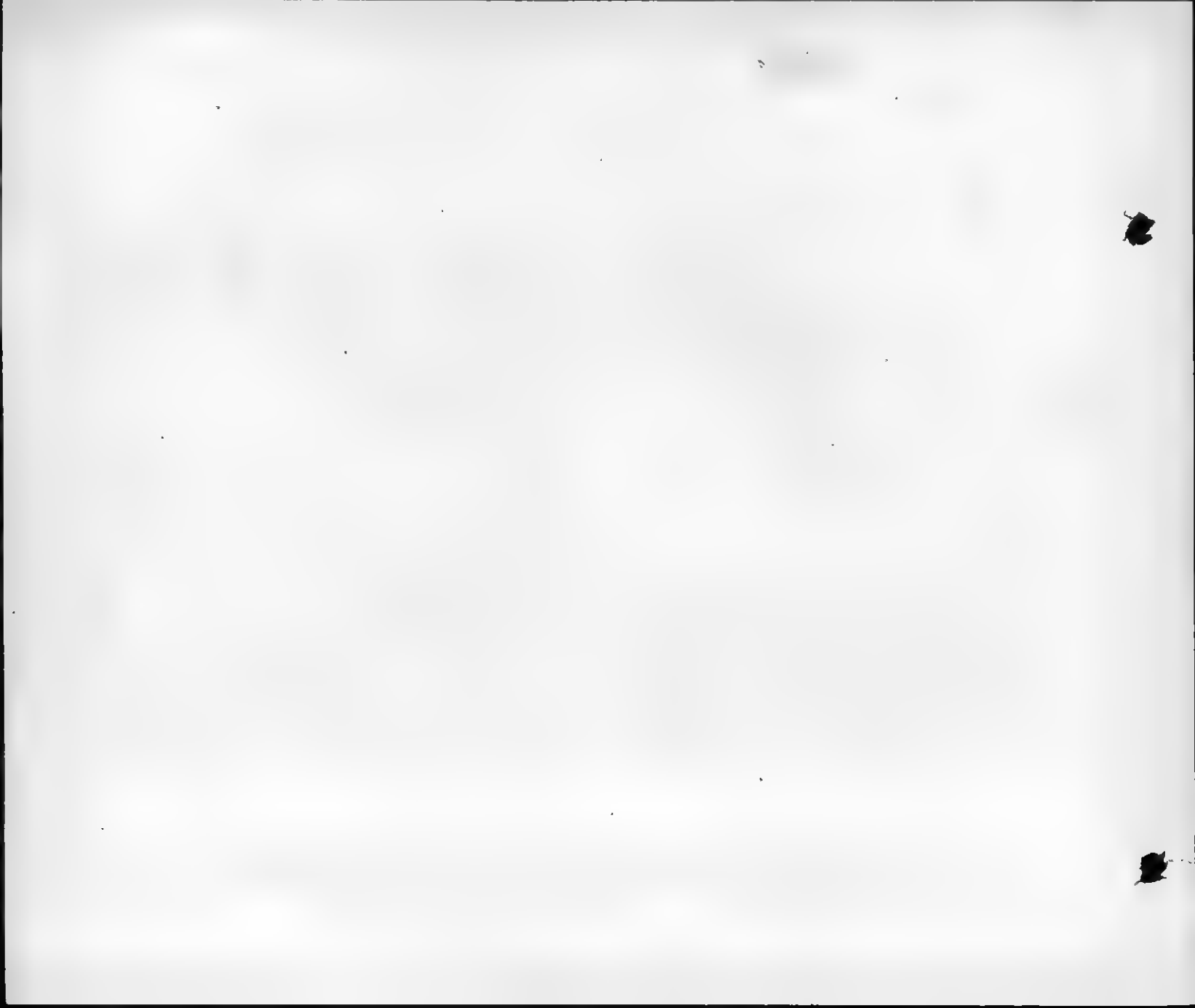


12985

CERTIFICATE OF DEATH

12900

1. PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Camp Springs		c. LENGTH OF STAY IN TB 4 Months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Potomac Heights			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF Hospital Andrews				d. STREET ADDRESS 101 Cedar Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle TIENTJEN Last QUINN				4. DATE OF DEATH Month November Day 15 Year 1960			
5. SEX Male		6. COLOR OR RACE CAU		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 2, 1924	
				9. AGE (In years last birthday) 36 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) OFFICER, Retired		10b. KIND OF BUSINESS OR INDUSTRY US Air Force		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U S	
13. FATHER'S NAME MICHAEL R. QUINN				14. MOTHER'S MAIDEN NAME LUISE THEE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO (If yes, give war or date of service) 1944-1960		17. INFORMANT Wife 101 Cedar Lane, Potomac Hgts, 'd			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		ACUTE MYELOGENOUS LEUKEMIA				INTERVAL BETWEEN ONSET AND DEATH 9 mo	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 24 FEB 1960, to 15 NOV 1960, that (I) (we) last saw the deceased alive on 15 NOV 1960, and that death occurred 8:20 AM, from the causes and on the date stated above.							
22a. SIGNATURE Andrew W. Butchko				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 15 NOV	
22c. PHYSICIAN'S NAME (Type) ANDREW W BUTCHKO, CAPT USAF MC				22d. ADDRESS USAF HOSP ANDREWS, ANDREWS AFB, WASH 25, DC			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 18 NOV. 1960		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL		23d. LOCATION (City, town, or county) (State) ARLINGTON VA.	
24. FUNERAL DIRECTOR'S SIGNATURE RINALDI FUNERAL HOME 816 HSL N.E. WASH 2 DC				25a. REC'D BY REGISTRAR DATE NOV 18 '60		25b. REGISTRAR'S SIGNATURE Arthur P. ...	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12932

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12937

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY 1			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 31			
d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION Prince George				e. STREET ADDRESS 1516 62nd. Place S.E.			
3. NAME OF DECEASED (Type or print) First Anne Middle Mary Last Raum				4. DATE OF DEATH Month Nov. Day 24 Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 25th 1887	9. AGE in years 73	10. IF UNDER 1 YEAR Months 2 Days 28 Hours 0 Min 0		11. IF UNDER 24 HRS Hours 0 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of work on life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Chicago Ill		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Smith				14. MOTHER'S MAIDEN NAME Annie			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT Daniel R. Raum Carmody Hills Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Stroke in occ. of the left car. 4:20.0 DUE TO (b) at the left ventricle Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. Arterio Sclerosis of the DUE TO (c) Arterio Sclerosis of the							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11-21-1960 to 11-24-1960 that (I) (we) last saw the deceased alive on 11-23-1960 , and that death occurred at 12:55 A.M. from the causes and on the date stated above							
22a. SIGNATURE Hans Wodak				22b. DATE 11-24-1960			
22c. PHYSICIAN'S NAME (Type) Hans Wodak				22d. ADDRESS 9E Parkway Greenbelt, Md.			
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-28-60		23c. NAME OF CEMETERY OR CREMATORY Washington National		23d. LOCATION (City, town, or county) (State) Suitland Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. 517 11th St. S.E. Wash. D.C.				25a. REC'D BY REGISTRAR NOV 28 '60		25b. REGISTRAR'S SIGNATURE Caroline S. Harris	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12955

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>DIST. of Columbia</u> b. COUNTY <u>WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALZER</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CIVIL ANGLE SANITARIUM</u>		d. STREET ADDRESS <u>2012 PERRY ST. N.E.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>HELEN R REED</u>		4. DATE OF DEATH Month Day Year <u>11 22 1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-7-1875</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>+</u>	
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>SKYVESTER REED</u>		14. MOTHER'S MAIDEN NAME <u>CHARLOTTE VANAMBER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>UNKNOWN</u>		16. SOCIAL SECURITY NO. <u>577-18-6763</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Apoplexy (334)</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>arteriosclerotic Dementia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8-16 hrs</u> <u>Swing</u>	
19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-21-</u> 19 <u>60</u> to <u>11-22-</u> 19 <u>60</u> that I last saw the deceased alive on <u>11-22-</u> 19 <u>60</u> , and that death occurred at <u>7:30</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ernest P. Williams</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>Lawrence Sanitarium 11-22-60</u>	
PHYSICIAN'S NAME (Type) <u>ERNEST P. WILLIAMS</u>		<u>LAWRENCE SANITARIUM</u>	
22a. BURIAL, CREMATION OR REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/25/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John S. H. Jones Co.</u>		24a. REGISTERED BY <u>2905-14th St. N.W. Wash. D.C.</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur J. Thomas</u>		DATE <u>NOV 29 1960</u>	



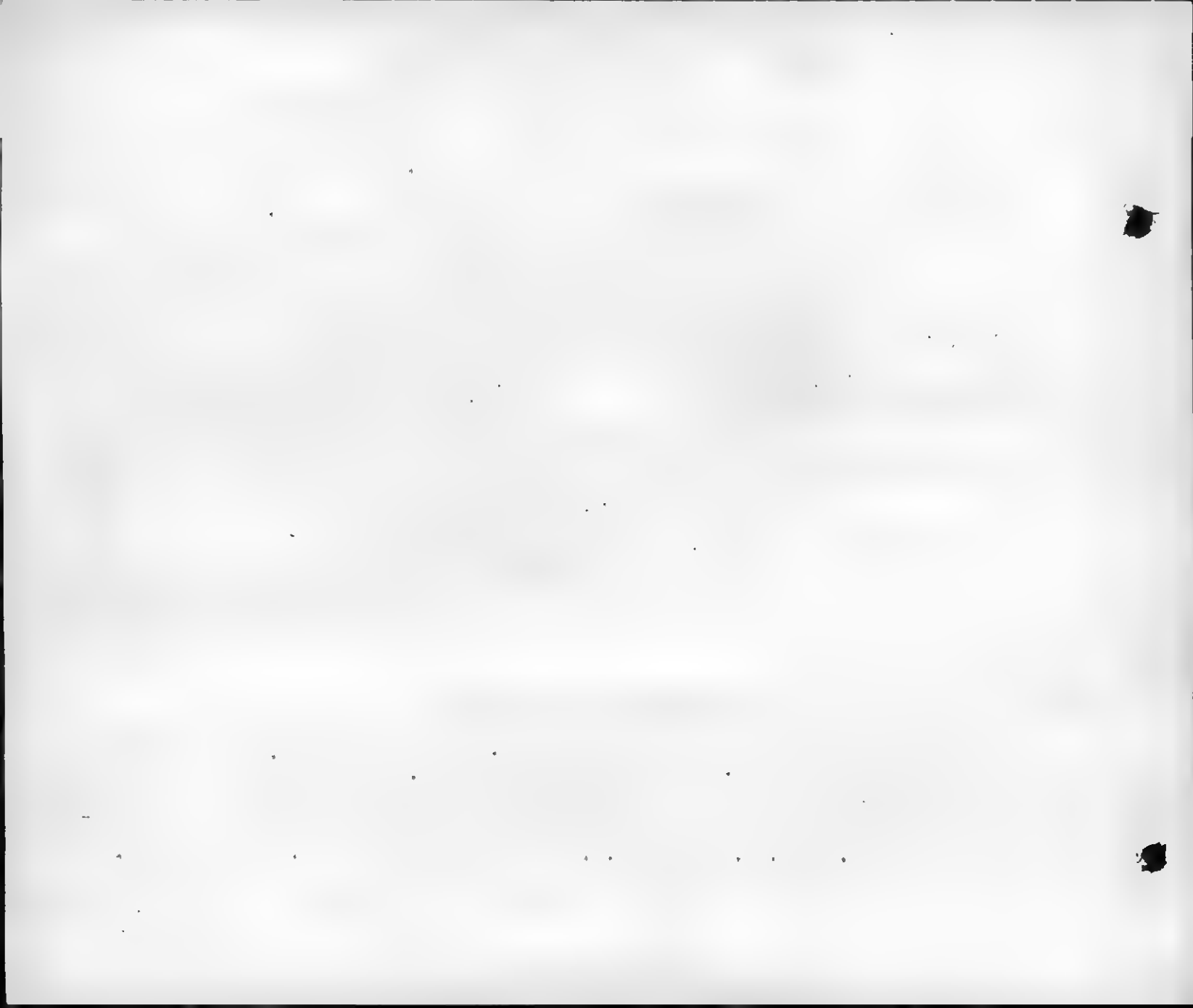
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12933

12933

1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 6 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 14000 36th St.			
3. NAME OF DECEASED (Type or print) Linda B Reed				4. DATE OF DEATH Nov 27 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 21 July 1907	
9. AGE (In years last birthday) 53 yrs		10a. USUAL OCCUPATION (Give kind of work done during any of working life, even if retired) Clerk - Peoples Drug Store		10b. KIND OF BUSINESS OR INDUSTRY Orange, Virginia		11. BIRTHPLACE (State or foreign country) U.S.	
13. FATHER'S NAME Henry Wakley				14. MOTHER'S MAIDEN NAME Mollie Gallahue			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 579-203448		17. INFORMANT Mrs. Rhoda Lee Zell - Daughter			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple Pulmonary Emboli 42 DUE TO Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost Myocardial Infarction and mural thrombus DUE TO Thrombosis of Left anterior descending coronary DUE TO Coronary Arteriosclerotic heart disease				INTERVAL BETWEEN DEATH AND DEATH 24 hours 1 week 1 week 1 week years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) above							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year 19 Hour o. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from Nov. 21 1960 to Nov. 27 1960 , that (I) (we) last saw the deceased alive on Nov. 26 1960 , and that death occurred at 3:00AM from the causes and on the date stated above							
22a. SIGNATURE Chas. D. Connor, M.D.				22b. DATE SIGNED 11-27-60			
22c. PHYSICIAN'S NAME (Type) Dr. Chas. D. Connor, M.D.				22d. ADDRESS 5813 Landover Rd. Cheverly, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 11/29/60		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION (City, town or county) (State) Suitland Prince Georges, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Nalley's Funeral Home, Mt Rainier, Md.				25a. REC'D BY REGISTRAR DEC 1 '60		25b. REG. STRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



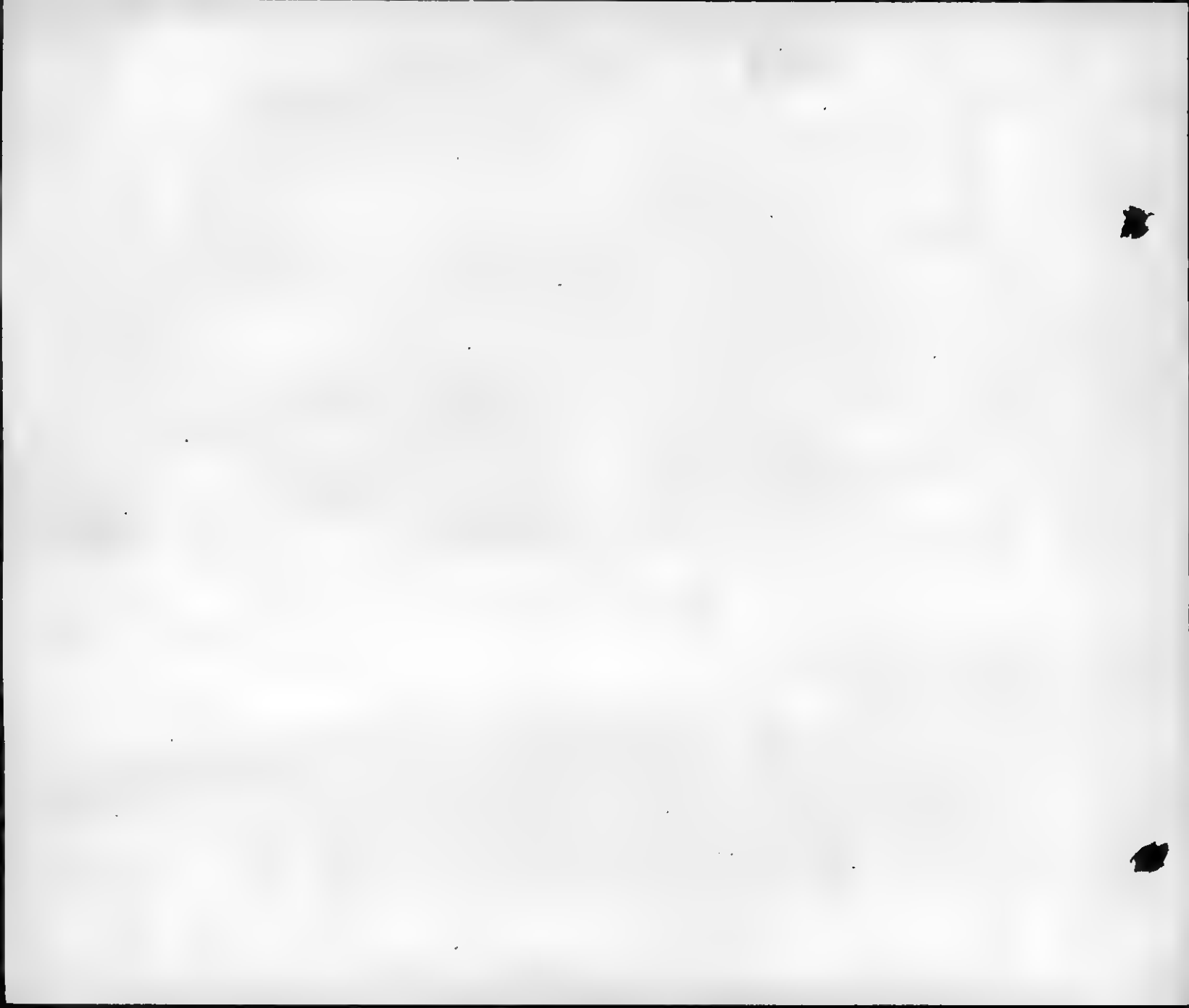
may be retained by the hospital or attending physician.
TUMERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12986

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12940

1 PLACE OF DEATH a. COUNTY PRINCE GEORGES b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE c. LENGTH OF STAY IN 1b 2 HRS 40 MIN d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSP ANDREWS, WASHINGTON, D C				2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE MARYLAND b. COUNTY DISTRICT OF COLUMBIA c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON d. STREET ADDRESS 1332 U ST SE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First JOHN Middle LOUIS Last RIOUX JR				4. DATE OF DEATH Month NOVEMBER Day 29 Year 19 60			
5 SEX MALE		6 COLOR OR RACE CAUCASIAN		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 29 NOVEMBER 1960	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months 2 Days 40		IF UNDER 24 HRS Hours 2 Min 40			
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) MARYLAND		12 CITIZEN OF WHAT COUNTRY? UNITED STATES	
13. FATHER'S NAME JOHN LOUIS RIOUX				14. MOTHER'S MAIDEN NAME FRANCES PATRICIA PEROW			
15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) NO		16 SOCIAL SECURITY NO. NONE		17. INFORMANT FATHER		Address SAME AS ITEM #2	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 762.5 Pulmonary atelectasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Prematurity (c) _____ PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ (b) _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH 3 hours 30 minutes 2 hours 40 min.	
19. WAS AN AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) _____ (County) _____ (State) _____	
21 I certify that (I) (this hospital) attended the deceased from 29 Nov 1960 to 29 Nov 1960 , that (I) last saw the deceased alive on 29 Nov 1960 , and that death occurred at 4:10 PM , from the causes and on the date stated above.							
22a SIGNATURE LEO R. KAIRYS				M D <input checked="" type="checkbox"/> ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b DATE SIGNED 29 NOVEMBER 1960	
22c PHYSICIAN'S NAME (Type) LEO R KAIRYS CAPT USAF (MC)				22d. ADDRESS USAF HOSP ANDREWS, ANDREWS AFB, WASH 25, DC			
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE THEREOF 1 DEC. 1960		23c NAME OF CEMETERY OR CREMATORY Arlington National		23d LOCATION (City, town, or county) Arlington Va. (State) _____	
24 FUNERAL DIRECTOR'S SIGNATURE Rinaldo Fumard Home ADDRESS 816 H St. NE Wash 25				25a REC'D BY REG STRAR DEC 1 '60		25b REGISTRAR'S SIGNATURE C. S. 8 Times	



TO DEATH MEDICAL EXAMINER: This certificate should be executed within 4 hours after death. If a delay is necessary, please forward the certificate, writing the word "pending" in pencil in 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Pages 1 and 2 may be retained for your files. File pages 3 and 4 with the State Board of Health. If the death is designated agent, prior to burial, cremation, or removal, and if any event within 72 hours after death.

VS. A15ME
5M 7/59

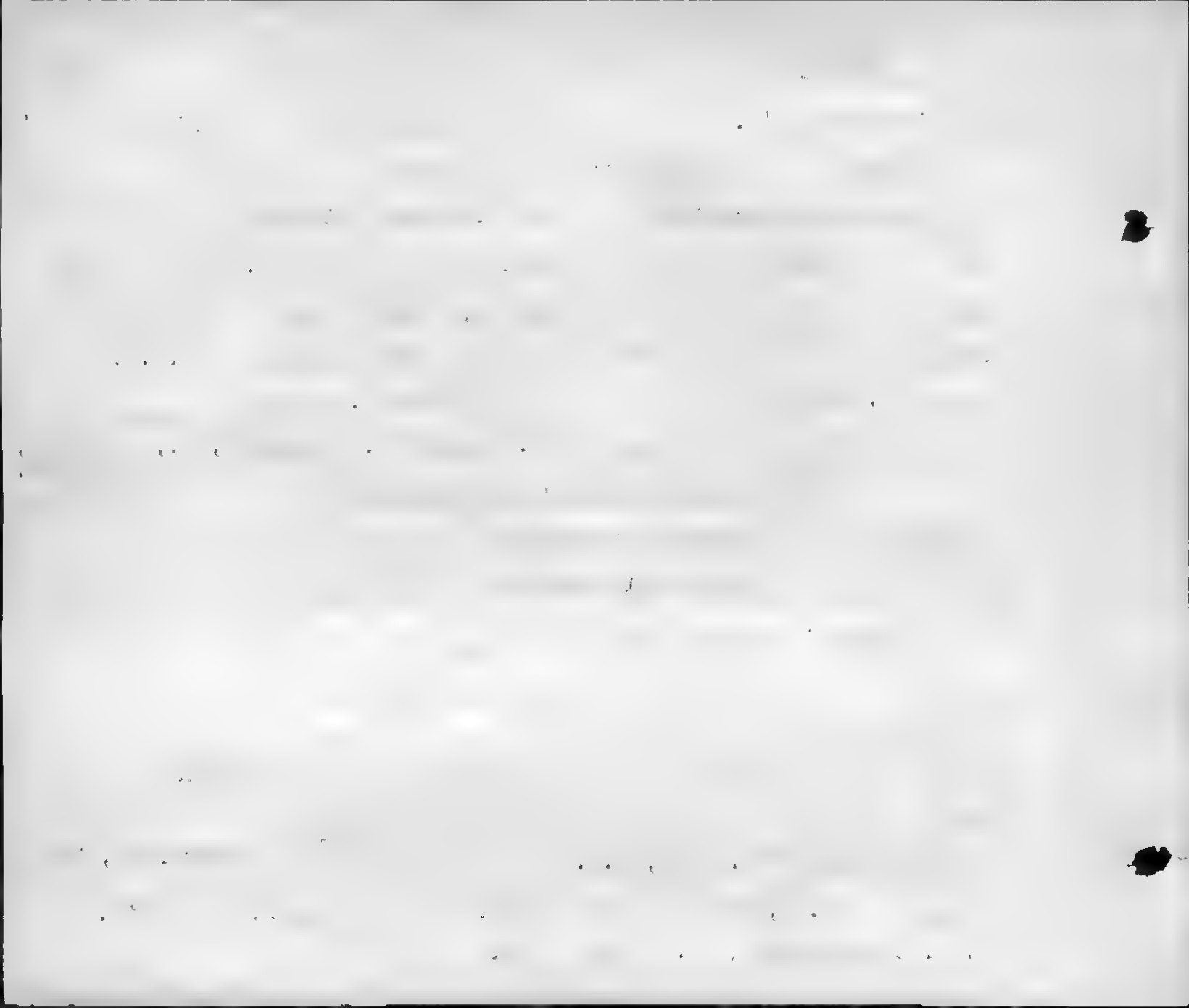
1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1296 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12941

1. PLACE OF DEATH a. COUNTY Prince George's, MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN TB 8 Hours	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Leland Memorial Hospital		d. STREET ADDRESS 20 Laurel Hill Road	
3. NAME OF DECEASED (Type or print) JUDY LYNN ROBERTSON		4. DATE OF DEATH Nov. 20 1960	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED		8. DATE OF BIRTH May 3, 1951	
9. AGE (In years last birthday) 9 yrs.		10. AGE (In years last birthday) 9 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY At School	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Norman L. Robertson		14. MOTHER'S MAIDEN NAME Ruthalee V. Ervin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None None		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Ruthalee V. Robertson, Rd., Greenbelt, Md.		Address 20 Laurel Hill	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Intestinal Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Intestinal purpura DUE TO (c) Penicillin Reaction		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) Sclerotic Lesion of Brain		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 23, 1960	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or country) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR W. W. CHAMBERS CO., Riverdale, Md.		24a. REC'D BY REGISTRAR NOV 23 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		DATE	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12987 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12942

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Camp Springs</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Westmont Heights</u>	
c. LENGTH OF STAY IN 1b <u>Deedman</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Westmont Heights</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Annapolis Base Hospital</u>		d. STREET ADDRESS <u>7618 Atwood St</u>	
3. NAME OF DECEASED (Type or print) <u>Richard Gary Robinson</u>		4. DATE OF DEATH <u>Nov 22 1960</u>	
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>10-21-60</u>		9. AGE (in years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. <u>8</u> yrs. <u>8</u> months <u>8</u> days <u>8</u> hours <u>8</u> min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Joseph Robinson</u>		14. MOTHER'S MAIDEN NAME <u>Alice Elizabeth Neegan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>John Joseph Robinson, same as #2</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONIA, LOBULAR, BILATERAL</u>		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James J. Boyd</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
NAME (Type) <u>James J. Boyd</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Nov. 25, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL</u>		22d. LOCATION (City, town, or country) (State) <u>ARLINGTON VA.</u>	
23. FUNERAL DIRECTOR <u>FINARDI FUNERAL HOME, INC.</u>		24a. REC'D BY REGISTRAR <u>NOV 28 '60</u>	
ADDRESS <u>816 H St. N.E. DC</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Kinnear</u>	

VS. A15M
5M 2109

VS



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AIS (4)
15M 9/59

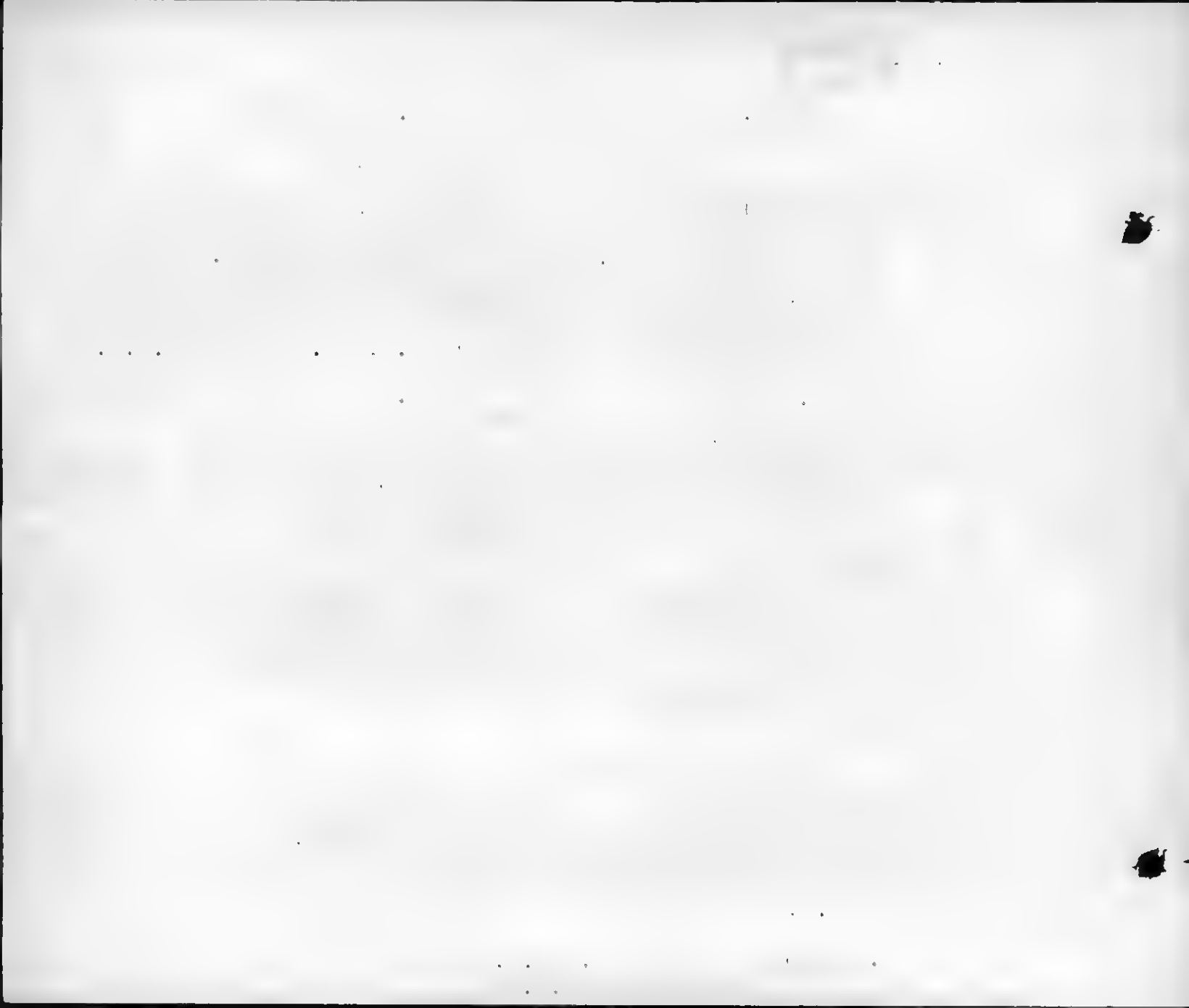
12967

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12943

1. PLACE OF DEATH a. COUNTY LELAND MEM. HOSPITAL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE PA. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RIVERDALE		c. LENGTH OF STAY IN 1b 15 x 3	
d. NAME OF HOSPITAL (If not in hospital, give street address) LELAND MEM. HOSPITAL		d. STREET ADDRESS 1304 FAWCETT AVE.,	
3. NAME OF DECEASED (Type or print) CORA		4. DATE OF DEATH Nov. 16 19 60	
5. SEX FEMALE	6. COLOR OR RACE COL.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/24/92
9. AGE (In years last birthday) 68 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DOMESTIC		10b. KIND OF BUSINESS OR INDUSTRY PITTS., PA.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM J. DADE		14. MOTHER'S MAIDEN NAME MARY E. SANDERS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 171-26-8726	
17. INFORMANT Mrs. HENRIETTA JOSEPH		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary heart attack DUE TO (b) arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIF. CANT CONDIT. ONS CONTR. BUT NG TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bell's Palsy			
INTERVAL BETWEEN ONSET AND DEATH 1 hour 3 yrs			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Aug 19, 1960 to Nov 1, 1960 that (I) (we) last saw the deceased alive on Nov 1, 1960 and that death occurred at 2:15 A.M. from the causes and on the date stated above			
22a. SIGNATURE W.S. HUDSON M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
22b. DATE 11/2/60			
22c. PHYSICIAN'S NAME (Type) W.S. HUDSON			
22d. ADDRESS 509 R.I. ave NW			
23a. BURIAL, CREMATION REMOVAL (Specify) BURIAL			
23b. DATE THEREOF 11.4.60			
23c. NAME OF CEMETERY OR CREMATORY McKEESPORT, PA.			
23d. LOCATION (City, town, or county) (State)			
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT G. MCGUIRE			
ADDRESS 1820 9TH ST., N.W.			
25a. REC'D BY REGISTRAR NOV 4 '60			
25b. REGISTRAR'S SIGNATURE Cuthbert S. Thomas			

WASHINGTON 1, D.C.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

FOR STATE
HEALTH DEPT.

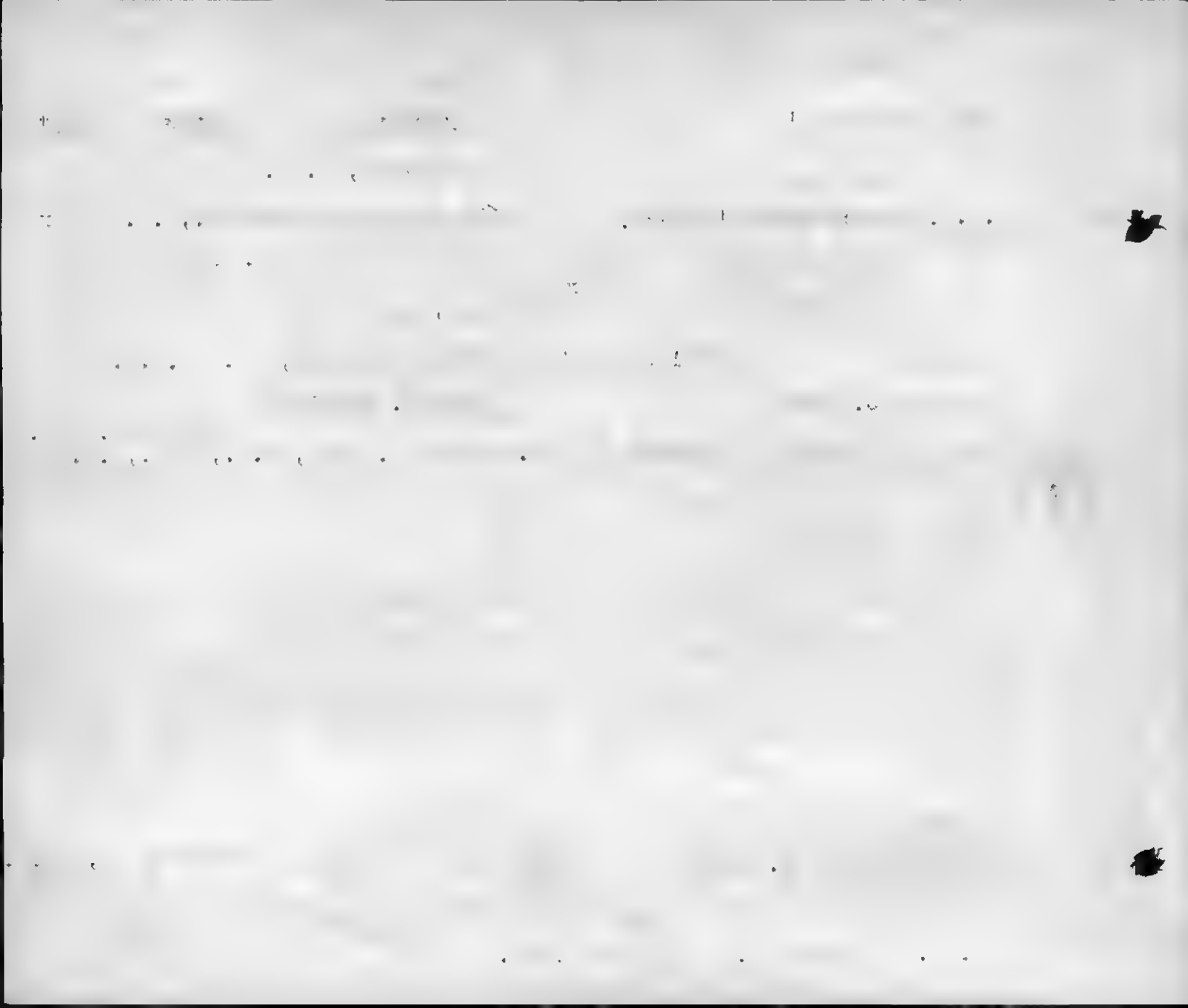
MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12934 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12944

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) D.O.A. Prince George's Hosp.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE'S c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington, D. C. d. STREET ADDRESS 1630 Massachusetts Ave., S.E.	
3. NAME OF DECEASED (Type or print) Ivan Houston Rowe		4. DATE OF DEATH Month Day Year Nov. 18, 1960	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Month Day Year July 17, 1937	
9. AGE (In years last birthday) 23 yrs.		10. IF UNDER 1 YEAR Months Days 23	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attendant		10b. KIND OF BUSINESS OR INDUSTRY Service Station	
11. BIRTHPLACE (State or foreign country) Moffattes Creek, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard C. Rowe		14. MOTHER'S MAIDEN NAME Ethel M. Hardison	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. 226-44-0811	
17. INFORMANT Mr. Richard C. Rowe, S.E., Wash., D.C.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia DUE TO (b) acute Carbon monoxide poisoning DUE TO (c) cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). Found on seat of his car with motor running			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Found on seat of his car with motor running	
20c. TIME OF INJURY Month, Day, Year Nov. 11 - 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Car		20f. (City or town) (County) (State) Washington National Suitland, Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) James I. Boyd		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-22-1960	
22c. NAME OF CEMETERY OR CREMATORY Washington National		22d. LOCATION (City, town, or country) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR W. W. CHAMBERS CO., Riverdale, Md.		24a. REC'D BY REGISTRAR NOV 23 60	
24b. REGISTRAR'S SIGNATURE Arthur S. Thomas		DATE SIGNED November 18, 1960.	

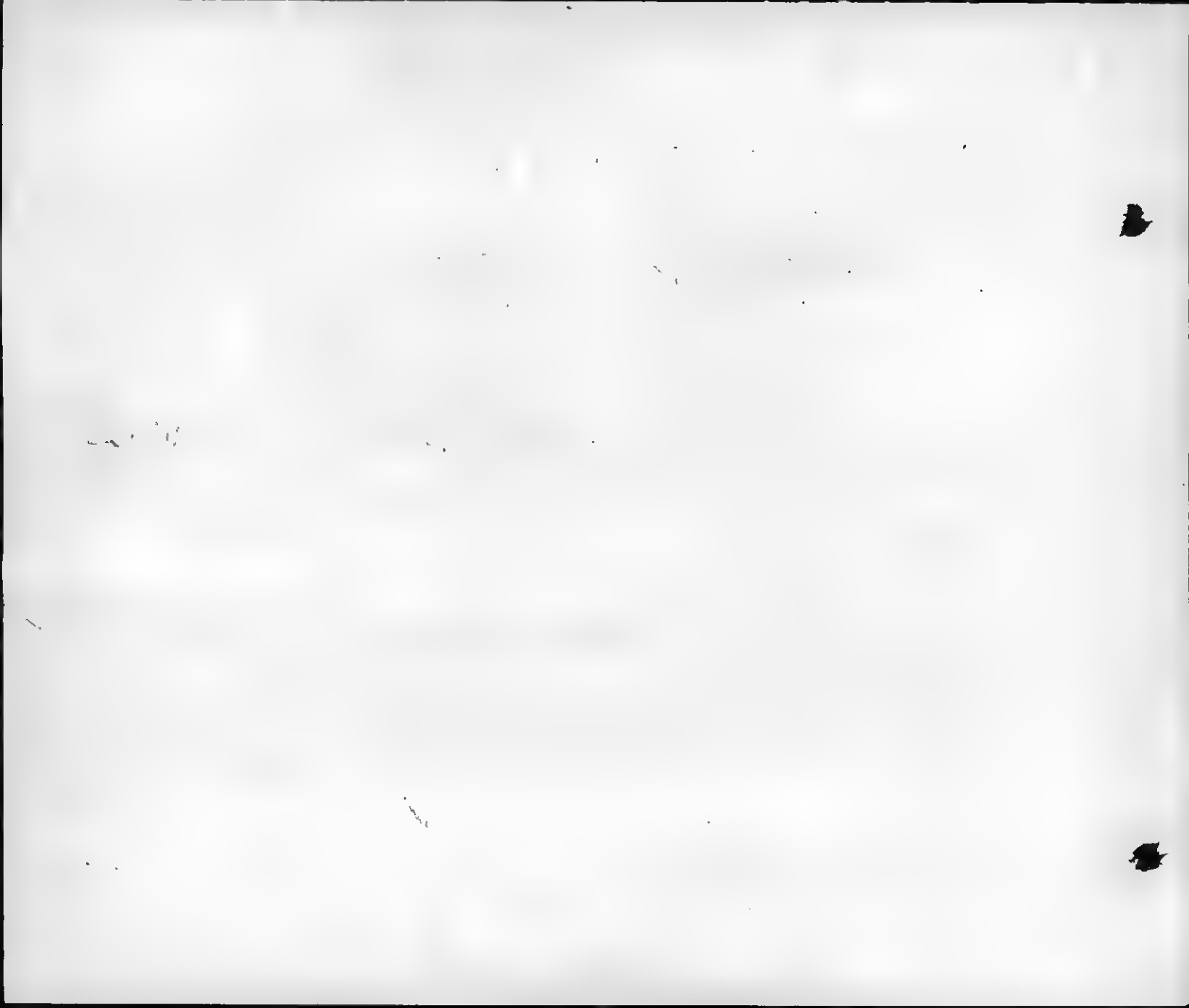


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12935

12935

1 PLACE OF DEATH a. COUNTY <u>Prince George's County</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived f institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry</u>				c. LENGTH OF STAY IN 1b <u>D.O.A.</u>			
d. NAME OF HOSPITAL (If not a hospital, give street address) OR INSTITUTION <u>Prince George's Hosp.</u>				d. STREET ADDRESS <u>Calvin Avenue Md</u>			
3 NAME OF DECEASED (Type or print) <u>Alexander Carl</u> First <u>RUPARD</u> Middle Last				4. DATE OF DEATH Month <u>Nov</u> Day <u>25</u> Year <u>1960</u>			
5 SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>JAN 17, 1902</u>	
9 AGE (In years last birthday) <u>58</u> yrs		IF UNDER 1 YEAR Months <u>10</u> Days <u>8</u>		IF UNDER 24 HRS Hours <u></u> Min <u></u>			
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>trimmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Bldg.</u>		11. BIRTHPLACE (state or foreign country) <u>VIRGINIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>US</u>							
13. FATHER'S NAME <u>Joseph M</u> <u>RUPARD</u>				14. MOTHER'S MAIDEN NAME <u>Rachael</u> <u>TAYLOR</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>1919-1920</u>				16. SOCIAL SECURITY NO. <u>574-103782</u>		17 INFORMANT <u>James #2</u> <u>RUPARD</u> (Wife) Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>Arteriosclerotic Cardiovascular Disease</u> (b) <u>and</u> DUE TO <u>Pulmonary Emphysema</u> (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cirrhosis of Liver</u> <u>chronic</u> <u>hepatitis</u> INTERVAL BETWEEN ONSET AND DEATH							
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c TIME OF INJURY Month, Day Year Hour o. m. p. m.		20d INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>Oct 9</u> 19 <u>60</u> , to <u>Nov 25</u> 19 <u>60</u> ; that (I) (we) last saw the deceased alive on <u>Nov 20</u> 19 <u>60</u> , and that death occurred at <u>3:20</u> PM, from the causes and on the date stated above							
22a. SIGNATURE <u>William D. Rosson</u> M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b DATE SIGNED <u>11/25/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>William D Rosson</u>				22d ADDRESS <u>5701 85th Ave, HYATTSVILLE, MD</u>			
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		23b DATE THEREOF <u>11-29-60</u>		23c NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Arldington Va.</u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>F. Paschi Sons</u>				25a REC'D BY REGISTRAR <u>NOV 29 1960</u> DATE		25b REGISTRAR'S SIGNATURE <u>Arthur S. Thum</u>	



TO HOSTS OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be examined by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12936

12946

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 13 Weeks d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier d. STREET ADDRESS 2501 Queens Chapel Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Barker H Sapp		4. DATE OF DEATH Month Nov. Day 23 Year 1960		5. SEX Male 6. COLOR OR RACE White			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH Feb. 23, 1893		9. AGE (In years last birthday) 67 yrs			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LYN TYPE OPERATOR		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) EASTON, PENN'A			
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JACOB SAPP		14. MOTHER'S MAIDEN NAME MARY FRICK			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 140-01-5992		17. INFORMANT MRS TERESA SAPP Address SAME AS #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Multiple Infarcts (c) Arteriosclerosis of Blood Vessels				INTERVAL BETWEEN ONSET AND DEATH 23 days 23 days 26 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary Arteriosclerosis				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o m. p m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 10-22 , 19 60 , to Nov. 23 , 19 60 , that (I) (we) last saw the deceased alive on 11-23 , 19 60 , and that death occurred at 9:20 AM , the causes and on the date stated above					
22a. SIGNATURE Dr. Saul Swartzback, M.D.		22b. DATE SIGNED Nov. 23, 1960		22c. PHYSICIAN'S NAME (Type) Dr. Saul Swartzback, M.D.			
22d. ADDRESS 1726 Ego St. New York, N.Y.		23a. BURIAL, CREMATION, or REMOVAL (Specify) BURIAL					
23b. DATE THEREOF 11-26-60		23c. NAME OF CEMETERY OR CREMATORY LOCUST HILL CEMETERY		23d. LOCATION (City, town, or county) (State) DOVER, NEW JERSEY			
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. Riverdale, Md.		25a. RECORDING REGISTRAR DATE NOV 28 1960		25b. REGISTRAR'S SIGNATURE Arthur J. Evans			



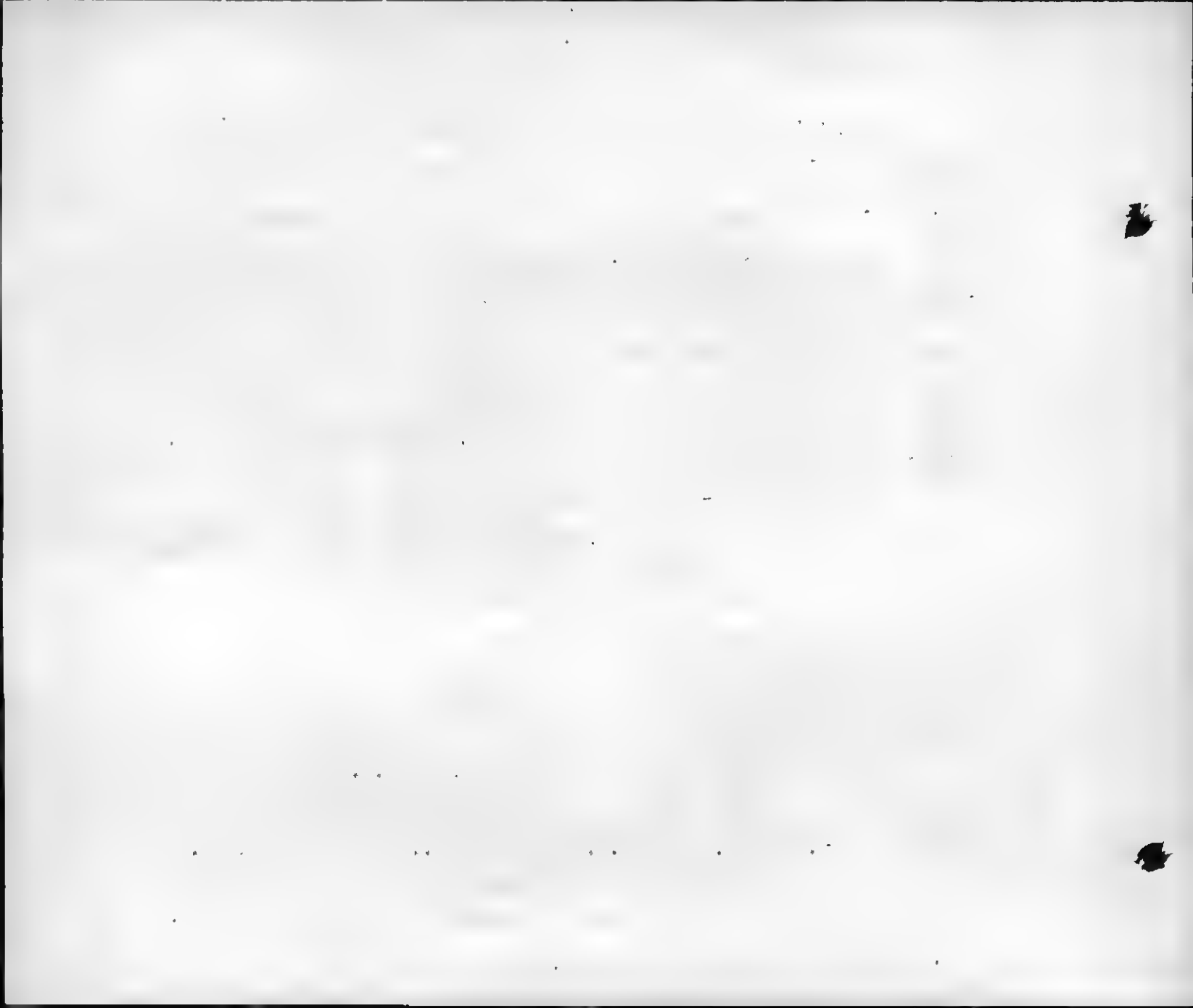
may be retained by the hospital or attending physician.
NO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12937

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12947

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b Riverdale			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3 NAME OF (Type or print) First Middle Last Lillyian G. Sarton				4. DATE OF DEATH Month Day Year November 22 1960			
5 SEX Female		6 COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-1-11	
9. AGE (In years last birthday) 49 yrs		F UNDER 1 YEAR: Months Days Hours Min		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U S A	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Virginia	
13 FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Address Robert A. Sarton Riverdale, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1-Myocardia Infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 2-Myocardia secondary to thrombosis of Left lateral Artery DUE TO (c) Arteriosclerotic Heart Disease							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from June 1942 to 11-22 1960 that (I) (we) last saw the deceased alive on 11-22 1960 and that death occurred 11:05 PM from the causes and on the date stated above							
22a. SIGNATURE John P. Clum				22b. DATE SIGNED 11-23-60		22c. PHYSICIAN'S NAME (Type) Dr. John P. Clum, M.D. 5110 43rd Ave., Hyattsville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov 25, 1960		23c. NAME OF CEMETERY OR INTERMENT Ft Lincoln Cemetery		23d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
24 FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.				25a. RECEIVED BY REGISTRAR NOV 28 1960		25b. REGISTRAR'S SIGNATURE Arthur J. Hume	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12938

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

12945

1. PLACE OF DEATH a. COUNTY <i>Prince George's</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Pr Geo</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chesley</i>				c. LENGTH OF STAY IN 1b <i>1 1/2 hrs</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Prince Geo General</i>				d. STREET ADDRESS <i>Box 470</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <i>MILTON H. SCHOFIELD</i>				4. DATE OF DEATH Month <i>Nov</i> Day <i>27</i> Year <i>1960</i>			
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>8-14-18</i>	
9. AGE (in years last birthday) <i>42</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Cook</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Laundry</i>			
11. BIRTHPLACE (State or foreign country) <i>Washington D.C.</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Milton H. Schofield</i>				14. MOTHER'S MAIDEN NAME <i>Marie E. Pace</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>577-09-5013</i>			
17. INFORMANT <i>Marie E. Schofield</i>				Address <i>Box 470 Landover Md.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Conjunctive Heart failure</i> INTERVAL BETWEEN ONSET AND DEATH <i>1 1/2 hrs</i> DUE TO (b) <i>myocardial infarct</i> <i>1 1/2 hrs</i> DUE TO (c) <i>occlusion left descending Branch</i> <i>1 1/2 hrs</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Coronary artery - Hypertensive Cardiovascular disease</i>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Dayton O Watkins</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <i>DAYTON O WATKINS</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				22b. DATE THEREOF <i>11-30-60</i>		22c. NAME OF CEMETERY OR CREMATORY <i>St. Lincoln Cem.</i>	
22d. LOCATION (City, town, or county) (State) <i>Phadensburg, Maryland</i>							
23. FUNERAL DIRECTOR'S SIGNATURE <i>W.W. CHAMBERS CO.</i>				ADDRESS <i>Riverdale, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>NOV 29 '60</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thoma</i>							



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a deputy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1
FOR STATE
HEALTH DEPT.

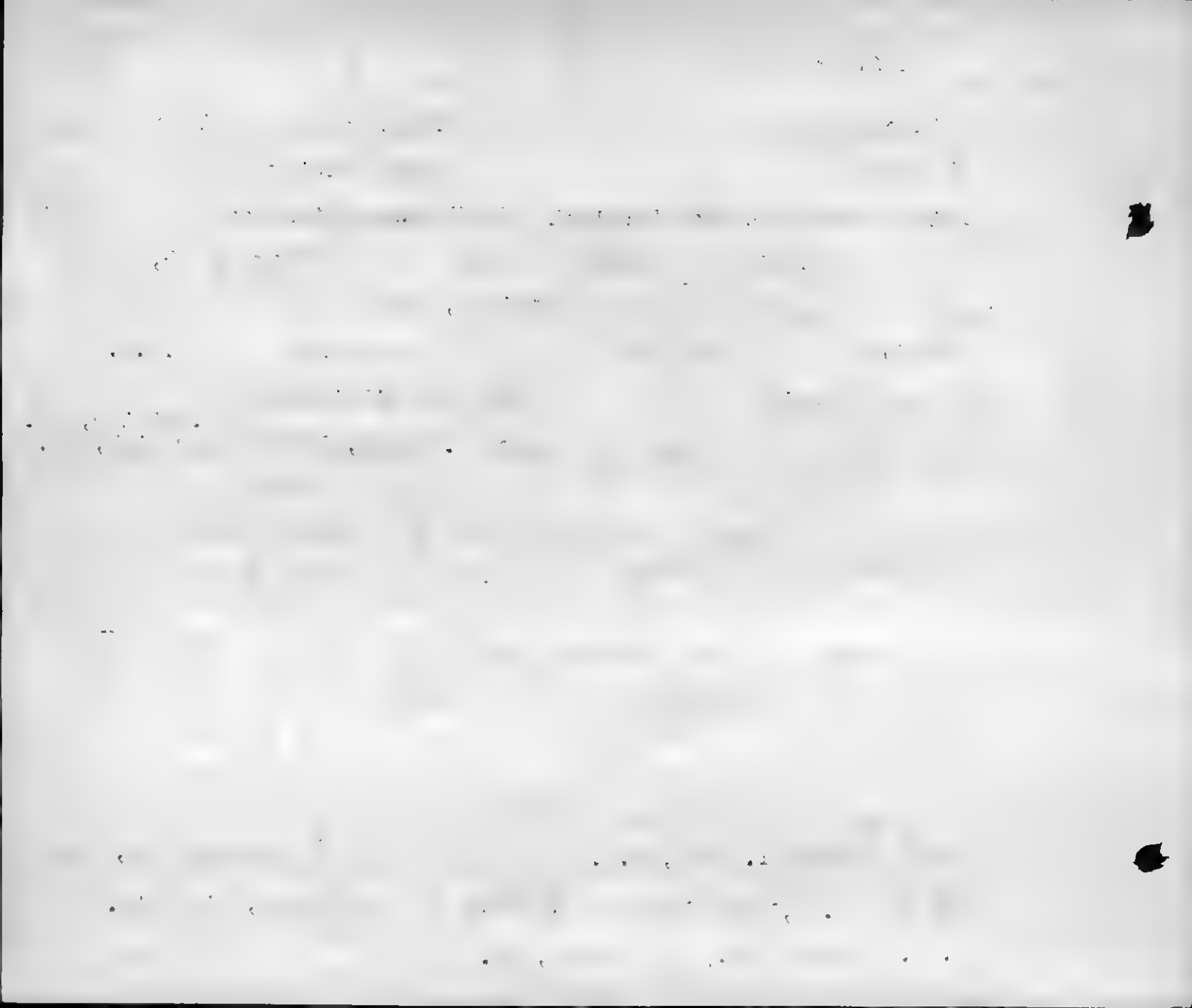
MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1293 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1294

1. PLACE OF DEATH a. COUNTY Prince George		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Rainier	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George General Hospital		d. STREET ADDRESS 3107 Bunker Hill Road	
3. NAME OF DECEASED (Type or print) CARRIE ELIZABETH SHENK		4. DATE OF DEATH November 9, 1960	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 9, 1898	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Francis		14. MOTHER'S MAIDEN NAME Isabelle Williamson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No None		16. SOCIAL SECURITY NO. None	
17. INFORMANT Joseph C. Shenk, 3107 Bunker Hill, Rd.		Address Mt. Rainier, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute pulmonary edema 422.5 DUE TO Conditions, if any, which gave rise to immediate cause (b) hypertensive heart disease - congestive (c) heart failure DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
NAME (Type) JAMES I. BOYD, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL OR CREMATION Burial		22b. DATE THEREOF Nov. 15, 1960	
22c. NAME OF CEMETERY OR CREMATORIUM Arlington National		22d. LOCATION (City, town, or country) (State) Arlington, Virginia.	
23. FUNERAL DIRECTOR W. W. CHAMBERS CO., Riverdale, Md.		24a. REC'D BY REGISTRAR NOV 15 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12940 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12950

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN 1b <u>D.O.A.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George General</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Pr. George</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>35 Glen Argen Woods</u> d. STREET ADDRESS <u>3204 Hayes St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Clayton</u> Middle <u>Brian</u> Last <u>Simpkins</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>2</u> Year <u>19 60</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>Sept. 5, 1958</u>			
9. AGE (In years last birthday) <u>2</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>child</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>			
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Edward W. Simkins Jr.</u>			
14. MOTHER'S MAIDEN NAME <u>Dorothy E. Williamson</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>E.W. Simkins -- as above</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonitis</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDIT ON GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Dayton O Watkins</u> NAME (Type) <u>Dayton O Watkins</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>11-9-60</u>			
22a. (BURIAL) CREMATION, REMOVAL (Specify) <u>11-14-60</u>		22b. DATE THEREOF <u>11-14-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat.</u>			
22d. LOCATION (City, town, or county) <u>Arlington Virginia</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>H.S. W. Robinson & Son</u>					
24a. REC'D BY REGISTRAR <u>NOV 14 '60</u>		24b. REGISTRAR'S SIGNATURE <u>C. H. King & Sons</u>					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for you.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



12988

CERTIFICATE OF DEATH

Reg. Dist. No.

12951

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillcrest Heights c. LENGTH OF STAY IN lb 7 yrs. d. NAME OF HOSPITAL (If not in hospital, give street address) 5806—28th Ave., S.E.		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Pr. George's Co. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillcrest Heights d. STREET ADDRESS 5806 - 28th Ave., S.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARY First O. Middle SLAUGHTER Last		4. DATE OF DEATH November 18th 1960 Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 17, 1894
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.	11. BIRTHPLACE (State or foreign country) New York
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Ora Chrissman	
14. MOTHER'S MAIDEN NAME Margaret Phillips		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO INFORMANT Address Wm. E. Slaughter 5806-28th Ave., S.E.		17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aemia DUE TO Retroperitoneal Lymphosarcoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) with Renal involvement DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH 6 weeks 8 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from January 1960 to Nov. 18, 1960 , that I last saw the deceased alive on Oct. 21, 1960 , and that death occurred at 2:55 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles E. Woodson M.D.		ADDRESS (Street city or town, state) 1801 Eye St. N.W. Washington 6, D.C.	
PHYSICIAN'S NAME (Type) CHARLES E. WOODSON		DATE SIGNED Nov. 18-1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 21-1960	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill	22d. LOCATION (City, town, or county) (State) Shutland Md.
23. FUNERAL DIRECTOR'S SIGNATURE immone 12/20/60 ADDRESS 1661—Good Hope Rd. SE Washington 20 DC		24a. REC'D BY REGISTRAR DATE NOV 21 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kline

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12989

CERTIFICATE OF DEATH

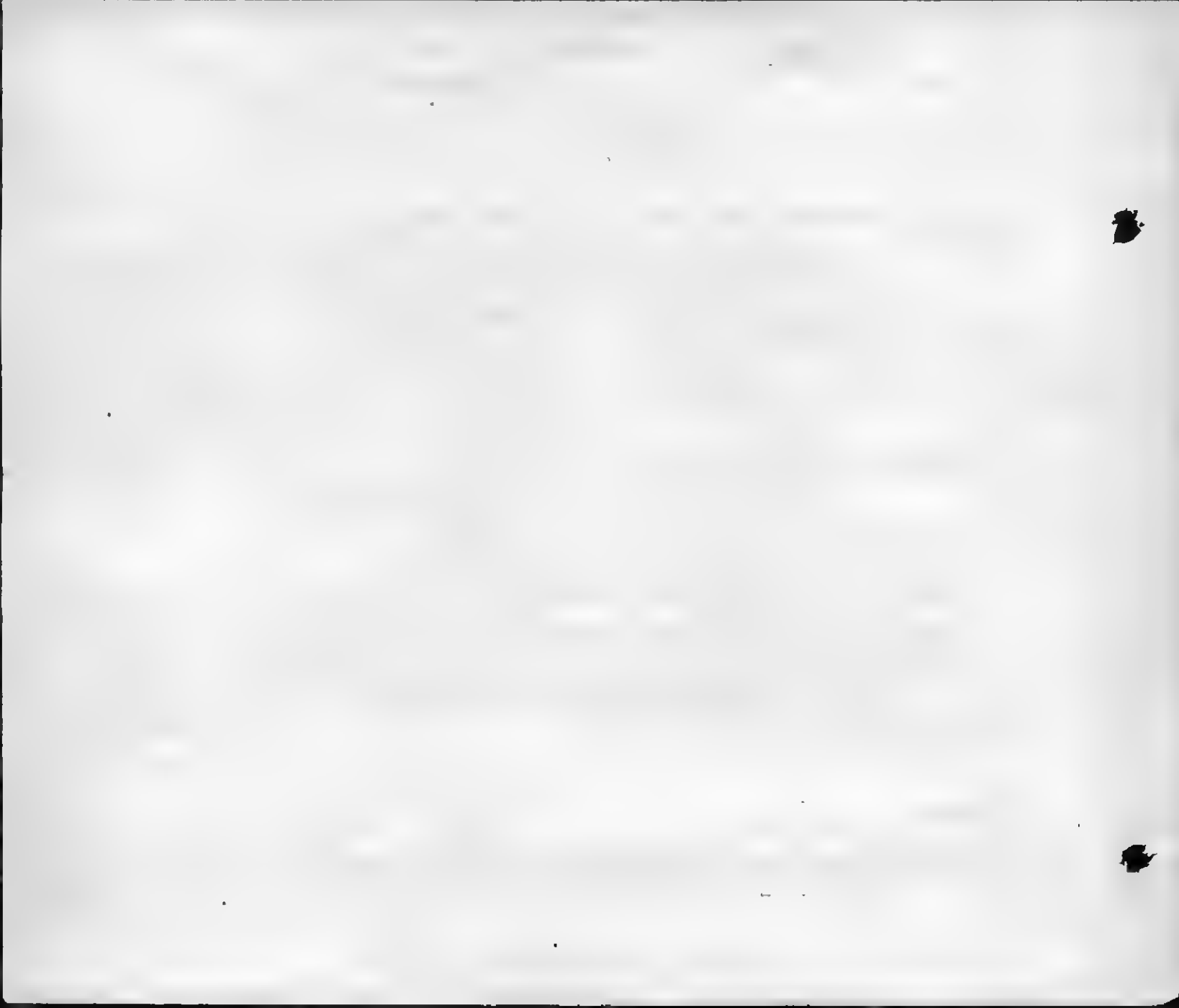
Reg. Dist. No.

12952

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Md. b. COUNTY Pr. G.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mitchellville				c. LENGTH OF STAY IN 1b 5yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Gas Smith				4. DATE OF DEATH Month Day Year Nov 16 1960			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11 21 1880	
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Tenant		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Andrew Smith				14. MOTHER'S MAIDEN NAME Eliza Coates			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Mary Smith Address Md. Box 34 Mitchellville,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Arteriosclerosis 44-2X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Arteriosclerotic Cardiovascular Renal Disease DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 3 yrs 10 yrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1 Sept 1960, to 16 Nov 1960, that I last saw the deceased alive on 16 Nov 1960, and that death occurred at 6:45 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE R. B. Basser				ADDRESS (Street, city or town, State) DATE SIGNED Upper Marlboro Md 16 Nov 60			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REBURYAL (Specify)		22b. DATE THEREOF 11-21-60		22c. NAME OF CEMETERY OR CREMATORY St. Marys Church		22d. LOCATION (City, town, or county) (State) Groome, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS 4339 Hunt Pl., N.E. Washington, D.C.		24a. REC'D BY REGISTRAR DATE Nov 21 '60	
				24b. REGISTRAR'S SIGNATURE			

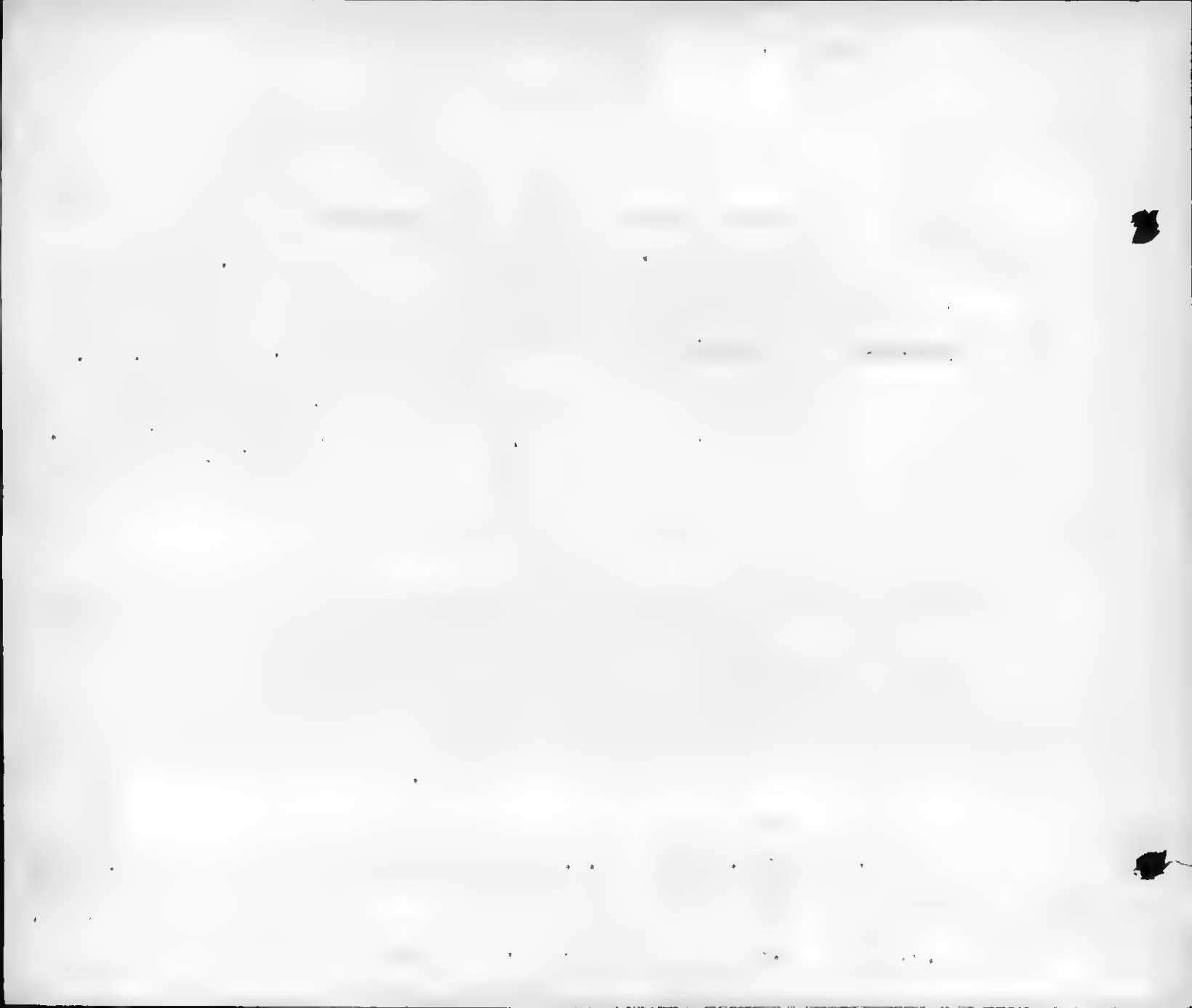
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



23c. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11/8/60	23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	23d. LOCATION (City, town, or county) Prince Georges County, Md.	(State)
24. FUNERAL DIRECTOR'S SIGNATURE The S.H.Hines Co.		ADDRESS 2901 14th St., N.W. Washington, D.C.	25a. REC'D BY REGISTRAR DATE NOV 7 '60	25b. REG. STRAR'S SIGNATURE <i>Arthur L. Krand</i>

VR A15 (4)
15M 9/59



12942

CERTIFICATE OF DEATH

Reg. Dist. No

1 PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>cheverly</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Camp Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ad-SACONDA CONVALESCENT HOME</u>		d. STREET ADDRESS <u>7369 BRINKLEY RD</u>	
3 NAME OF DECEASED (Type or print) First <u>EMMA</u> Middle <u>S</u> Last <u>STAUFFER</u>		4. DATE OF DEATH Month <u>NOV</u> Day <u>19</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 5 1890</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ms. Geo. Y.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Post Office</u>	
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Diehl</u>		14. MOTHER'S MAIDEN NAME <u>Kirknowl</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
INFORMANT <u>PAUL W. STAUFFER</u>		Address <u>7369 BRINKLEY RD</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchopneumonia, viral</u> 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>Syns</u>			INTERVAL BETWEEN ONSET AND DEATH <u>72 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JUNE</u> , 19 <u>60</u> , to <u>NOV 19</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Nov 19</u> , 19 <u>60</u> , and that death occurred at <u>5:55 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Norman Donat General</u> M.D.		ADDRESS (Street, city or town, state) <u>3503 Penny St</u> DATE SIGNED <u>11/19/60</u>	
PHYSICIAN'S NAME (Type) <u>Norman Donat General</u>		<u>MT CLARK MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11.22.60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home. 300. 4th st N E.</u>		24a. REC'D BY REGISTRAR <u>NOV 28 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Charles E. Thomas</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.


TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12990

12955

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE c. LENGTH OF STAY IN 1b DEAD ON ARRIVAL d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSP ANDREWS, ANDREWS AFB, WASH, DC		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE MARYLAND b. COUNTY DISTRICT OF COLUMBIA c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON d. STREET ADDRESS 2812 KEITH STREET, SE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EMERSON Middle LEROY Last STOCKS		4. DATE OF DEATH Month NOVEMBER Day 12 Year 19 60	
5. SEX MALE	6. COLOR OR RACE CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5 NOVEMBER 1927
9. AGE (In years, last birthday) 33 yes		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MEDICAL TECHNICIAN		10b. KIND OF BUSINESS OR INDUSTRY US AIR FORCE	
11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
13. FATHER'S NAME ERNEST FRANKLIN STOCKS		14. MOTHER'S MAIDEN NAME DECEASED	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. FEB 1946-60 234-38-9570	
17. INFORMANT AIR FORCE PERSONNEL RECORDS		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): 420 INFARCTION OF MYOCARDIUM DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE 7 MONTHS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 19 30 12 Nov 60, 17:30-12 Nov 60 that (I) (we) last saw the deceased alive 19 30-12 Nov 60 , and that death occurred at 7:30 PM , from the causes and on the date stated above.			
22a. SIGNATURE  M D		22b. DATE SIGNED 12 Nov	
22c. PHYSICIAN'S NAME (Type) ALBERT D CARILLI, CAPT USAF (MC)		22d. ADDRESS USAF HOSP ANDREWS, ANDREWS AFB, WASH 25, DC	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 16 Nov. 1960	
23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL		23d. LOCATION (City, town, or county) (State) ARLINGTON VA.	
24. FUNERAL DIRECTOR'S SIGNATURE RINALDI FUNERAL HOME		25a. REC'D BY REGISTRAR DATE NOV 15 '60	
ADDRESS 816 HST. N.E. DC 2		25b. REGISTRAR'S SIGNATURE Arthur S. Howard	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12991 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12956

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Coxon Run</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Coxon Run</u>	
c. LENGTH OF STAY IN b. <u>3 years</u>		d. STREET ADDRESS <u>2519 Southern Avenue</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>2519 Southern Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Florentyna Strzalkowska</u>	4. DATE OF DEATH <u>Nov 1 1960</u>	5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Nov 24, 1901</u> 9. AGE (In years last birthday) <u>58</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>Poland</u>	
13. FATHER'S NAME <u>Unknown</u>	14. MOTHER'S MAIDEN NAME <u>Unknown</u>	12. CITIZEN OF WHAT COUNTRY? <u>Poland</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>3 H. Strzalkowski</u> Address <u>2643-10th St NE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>774</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hanging</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Hanged self from Venetian blind</u>	
20c. TIME OF INJURY Month, Day, Year <u>Nov 1 - 1960</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) <u>Coxon Run</u> (County) <u>Baltimore</u> (State) <u>MD</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James T. Boyd</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JAMES T. BOYD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4 Nov 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>CONGRESSIONAL CEMETERY</u>		22d. LOCATION (City, town, or country) (State) <u>WASHINGTON DC</u>	
23. FUNERAL DIRECTOR <u>RINALDI FUNERAL HOME</u> ADDRESS <u>816 H St NE DC 2</u>		24a. REC'D BY REGISTRAR <u>Nov 3 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



12992

CERTIFICATE OF DEATH

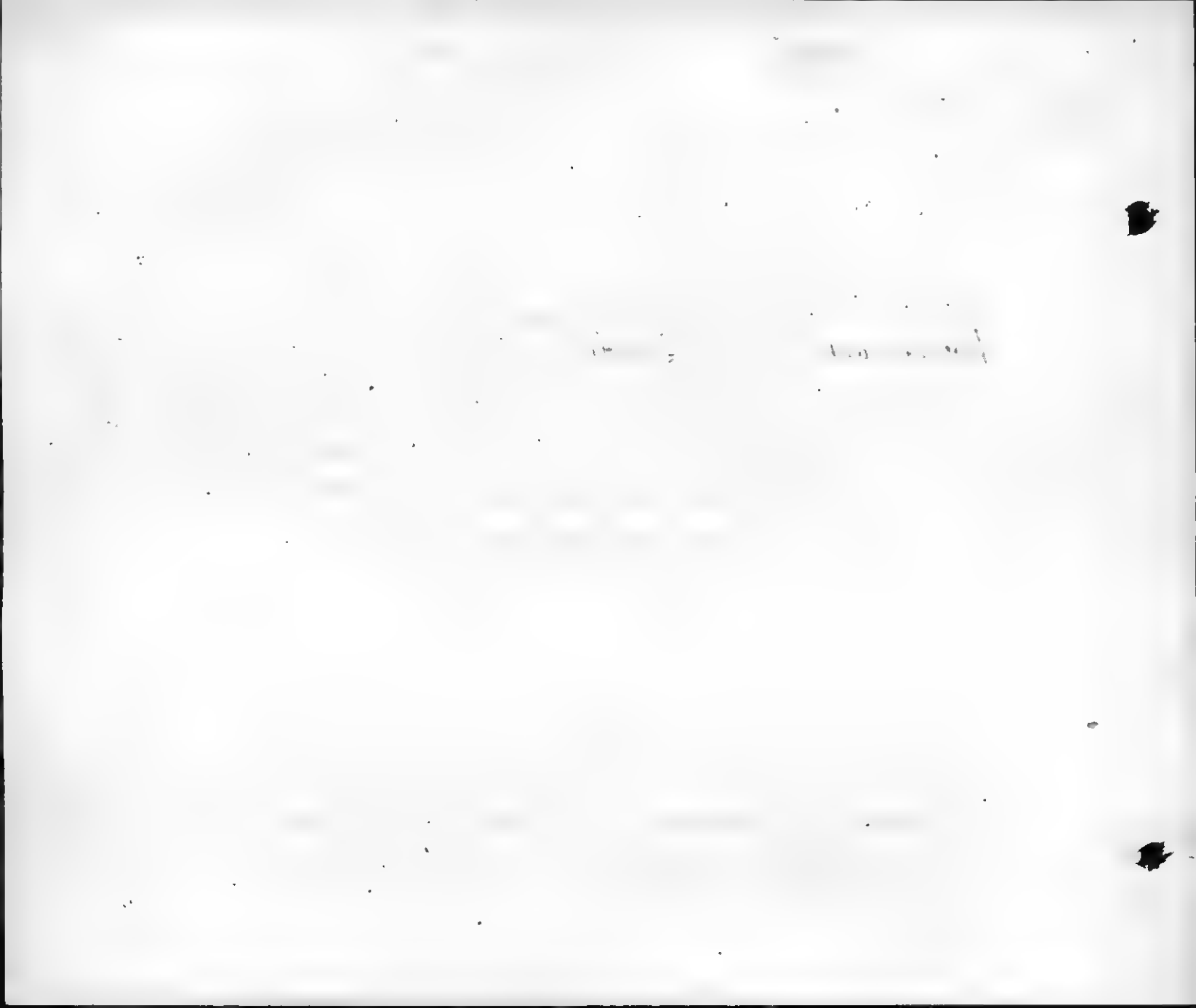
Reg. Dist. No.

12957

1 PLACE OF DEATH a. COUNTY <u>Prince Georges Co.</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u>				c. LENGTH OF STAY IN 1b <u>16 hrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Southern Maryland Hospital Center</u>				d. STREET ADDRESS <u>7 Faulkner</u>			
3 NAME OF DECEASED (Type or print) First Middle Last <u>Mary Grace Swann</u>				4. DATE DEATH Month <u>11</u> Day <u>17</u> Year <u>1960</u>			
5 SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>5-4-22</u>	
9 AGE (In years last birthday) <u>38</u> yrs		IF UNDER 1 YEAR Months <u>38</u> Days <u>38</u> Hours <u>38</u> Min <u>38</u>		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <u>Housework</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>		11. BIRTHPLACE (State or foreign country) <u>Charles Co., Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13 FATHER'S NAME <u>Walter Thompson</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Kessler</u>			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16 SOCIAL SECURITY NO <u>None</u>			
17 INFORMANT <u>William H. Thompson, (brother)</u>				Address <u>Post</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary edema & embolism</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive heart failure</u>							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>11/13</u> , 19 <u>60</u> , to <u>11/14</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>11/14</u> , 19 <u>60</u> , and that death occurred at <u>5:45</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Bernard Schneider</u> M.D.				ADDRESS (Street, city or town, state) <u>Southern Maryland Hosp</u> DATE SIGNED <u>11/14/60</u>			
PHYSICIAN'S NAME (Type) <u>BERNARD SCHNEIDER</u>				<u>Clinton</u> M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>11-16-60</u>		<u>St. Ignace Cmn.</u>		<u>Bel Air, Md.</u>	
23 FUNERAL DIRECTOR'S SIGNATURE <u>Heath Funeral Home</u>				ADDRESS <u>Waldorf, Md.</u>		24a. REC'D BY REGISTRAR <u>NOV 22 '60</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

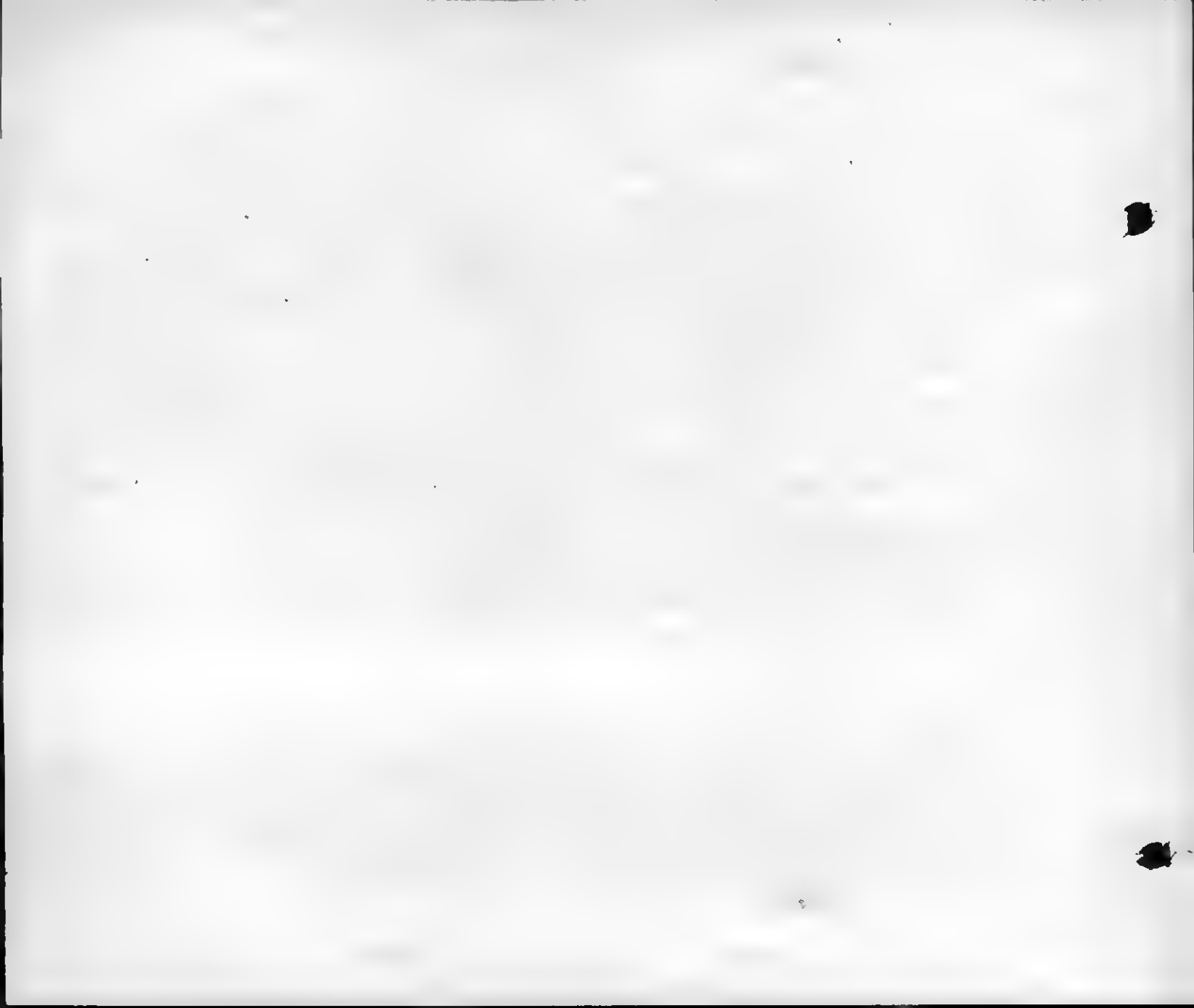
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12943

12956

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>			c. LENGTH OF STAY IN 1b <u>7 days</u>			CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fairmont Hgts</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General Hospital</u>				d. STREET ADDRESS <u>1008 60th St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Lilly</u> Middle <u>Thompson</u> Last <u>Thompson</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>4</u> Year <u>1960</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Black</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Unknown</u>		
9. AGE (In years last birthday) <u>82 yrs.</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u> </u>		
10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>H. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u> </u>				
13. FATHER'S NAME <u>Robert Davis</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Taylor</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>William Thompson</u> Address <u>Somerset #2</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>30 yr.</u>	
19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u> </u>							20c. TIME OF INJURY Month, Day, Year Hour a m p. m. <u> </u> <u> </u> <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) (County) (State) <u> </u>							21. I certify that (I) (this hospital) attended the deceased from <u>10/29</u> <u>1960</u> to <u>Nov 4</u> <u>1960</u> , that (I) (we) last saw the deceased alive on <u>11/4</u> <u>1960</u> , and that death occurred on <u>3:20 PM</u> from the causes and on the date stated above	
22a. SIGNATURE <u>Dr. Connors, MD</u> M.D.							22b. DATE SIGNED <u> </u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Connors, MD</u>							22d. ADDRESS <u>4410-74th Ave, Landover, Md.</u>	
23a. CREMATION REMOVAL (Specify) <u> </u>		23b. DATE THEREOF <u>11-9-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Nat. Harmony</u>		23d. LOCATION (City, town, or county) (State) <u>Landover Md.</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>H.S. Washington</u>							25a. REC'D BY REGISTRAR <u>APPROVED '60</u>	
25b. REGISTRAR'S SIGNATURE <u> </u>							25c. REGISTRAR'S SIGNATURE <u> </u>	



12892

1
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

12961

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>47X</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>				c. LENGTH OF STAY IN 1b <u>1 yr.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St. Elizabeth's Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles Robert</u>				4. DATE OF DEATH Month Day Year <u>November 25 1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 1 1917</u>	9. AGE (in years last birthday) <u>43 yrs</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>		11. BIRTHPLACE (State or foreign country) <u>Houston Texas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HARRY L. ALLAN</u>				14. MOTHER'S MAIDEN NAME <u>FANNIE MORGAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT <u>Dr. Eugene S. ...</u> Address <u>...</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> DUE TO <u>coronary atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>generalized arteriosclerosis</u> DUE TO (c) <u>death as a result of hip fracture with embolism</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>death as a result of hip fracture with embolism</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb</u> 19 <u>60</u> to <u>Nov 25 1960</u> , that (I) (we) last saw the deceased alive on <u>Nov 25 1960</u> , and that death occurred at <u>1:30 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>John R. Hewit</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11/25/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>John R. Hewit</u>				22d. ADDRESS <u>1756 Park Ave. NW</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>11/26/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>FRANKFORT</u>		23d. LOCATION (City, town, or county) (State) <u>FRANKFORT, KENTUCKY</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Joe. Fowler's Sons Inc.</u> ADDRESS <u>1756 Park Ave. NW</u>				25a. REC'D BY REGISTRAR DATE <u>NOV 28 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. ...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in only one place within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12993 CERTIFICATE OF DEATH

12962

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aguasco</u> c. LENGTH OF STAY IN 1b <u>Life</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Geo.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aguasco</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Olive</u> First <u>Watson</u> Middle <u>Trueman</u> Last				4. DATE OF DEATH <u>November 5</u> 19 <u>60</u> Month Day Year					
5. SEX <u>F</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 2</u> 18 <u>86</u> Yrs.		9. AGE (In years last birthday) <u>74</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>		11. BIRTHPLACE (State or foreign country) <u>Poplar Hill, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ELI Watson</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Trueman</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Robert H. Trueman, Aguasco, Md.</u> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442X</u> DUE TO <u>Cardiac</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>None</u> DUE TO <u>None</u> (c) <u>Aggravation</u>								INTERVAL BETWEEN ONSET AND DEATH <u>4 Days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11-1</u> , 19 <u>60</u> , to <u>11-5</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>11-5</u> , 19 <u>60</u> , and that death occurred at <u>4:00</u> M, from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED									
ACTUAL SIGNATURE <u>Theresa M. ...</u> M.D. <u>...</u>									
PHYSICIAN'S NAME (Type)									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 9, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Immanuel Meth.</u>		22d. LOCATION (City, town, or county) (State) <u>Baden, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hunt Funeral Home, Waldorf, Md.</u> ADDRESS						24a. REC'D BY REGISTRAR <u>...</u> DATE <u>NOV 14 '60</u>		24b. REGISTRAR'S SIGNATURE <u>...</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4. may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

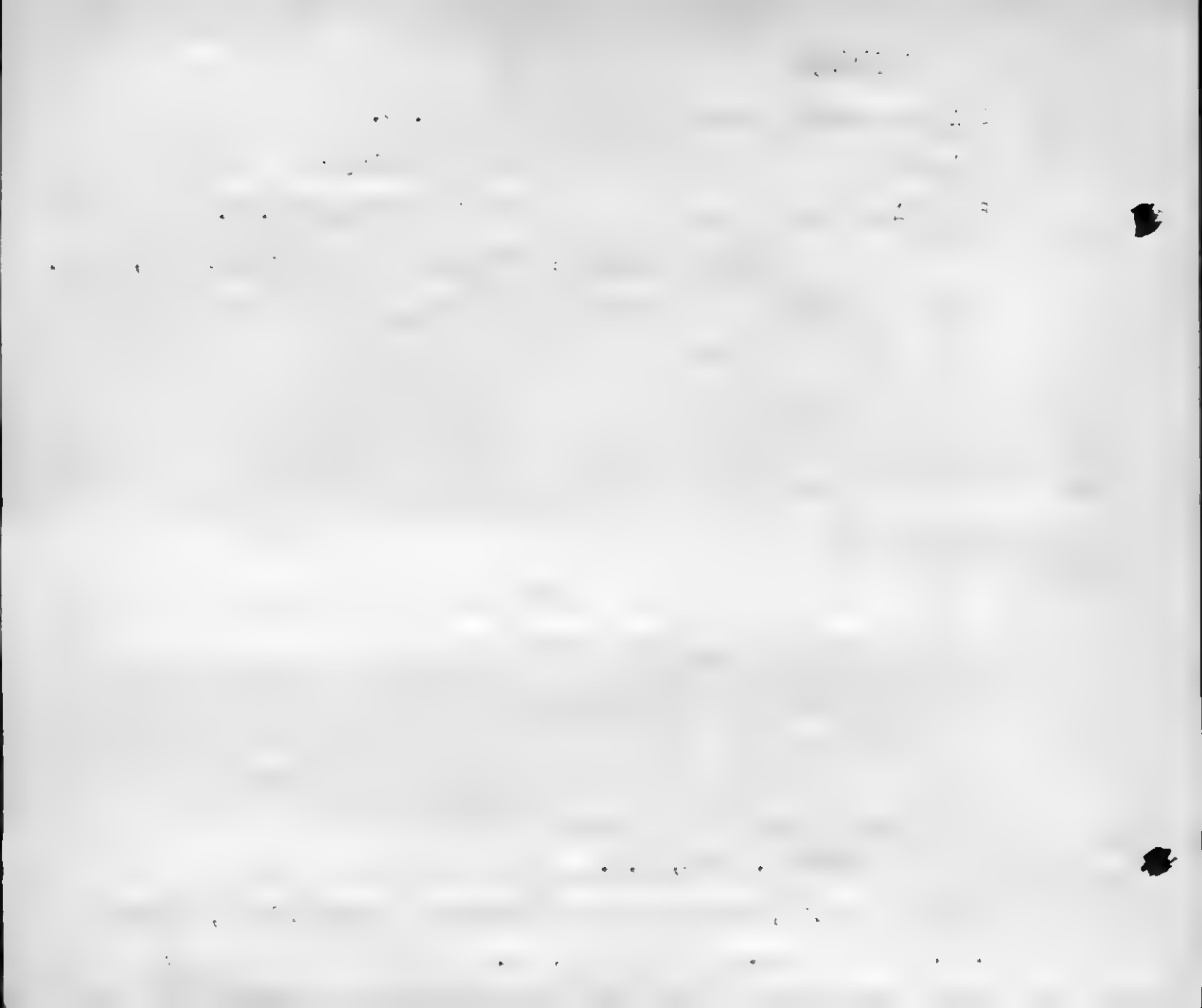
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12994 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12960

1. PLACE OF DEATH a. COUNTY Prince Georges County b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cnillum c. LENGTH OF STAY in lb MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 5926 Roggs Road		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE D. C. b. COUNTY None c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 4020 8th Street N. E.	
3. NAME OF DECEASED (Type or print) MAXTON RANDOLPH TURNER		4. DATE OF DEATH Month November Day 21 Year 1960	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 11, 1903	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10b. KIND OF BUSINESS OR INDUSTRY own business	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Bole Turner		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown, (If yes give war or dates of service) Yes WWI		16. SOCIAL SECURITY NO. 579-01-2924	
17. INFORMANT Mrs. Dona Turner, same as #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420 - 1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary artery disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a' 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 11-21-60			
ACTUAL SIGNATURE James I. Boyd NAME (Type) JAMES I. BOYD, M.D.		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 25, 1960	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Bladensburg, Maryland.	
23. FUNERAL DIRECTOR W. W. CHAMBERS CO., Riverdale, Md.		24a. REC'D BY REGISTRAR NOV 28 '60	
24b. REGISTRAR'S SIGNATURE Arthur J. Thomas			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

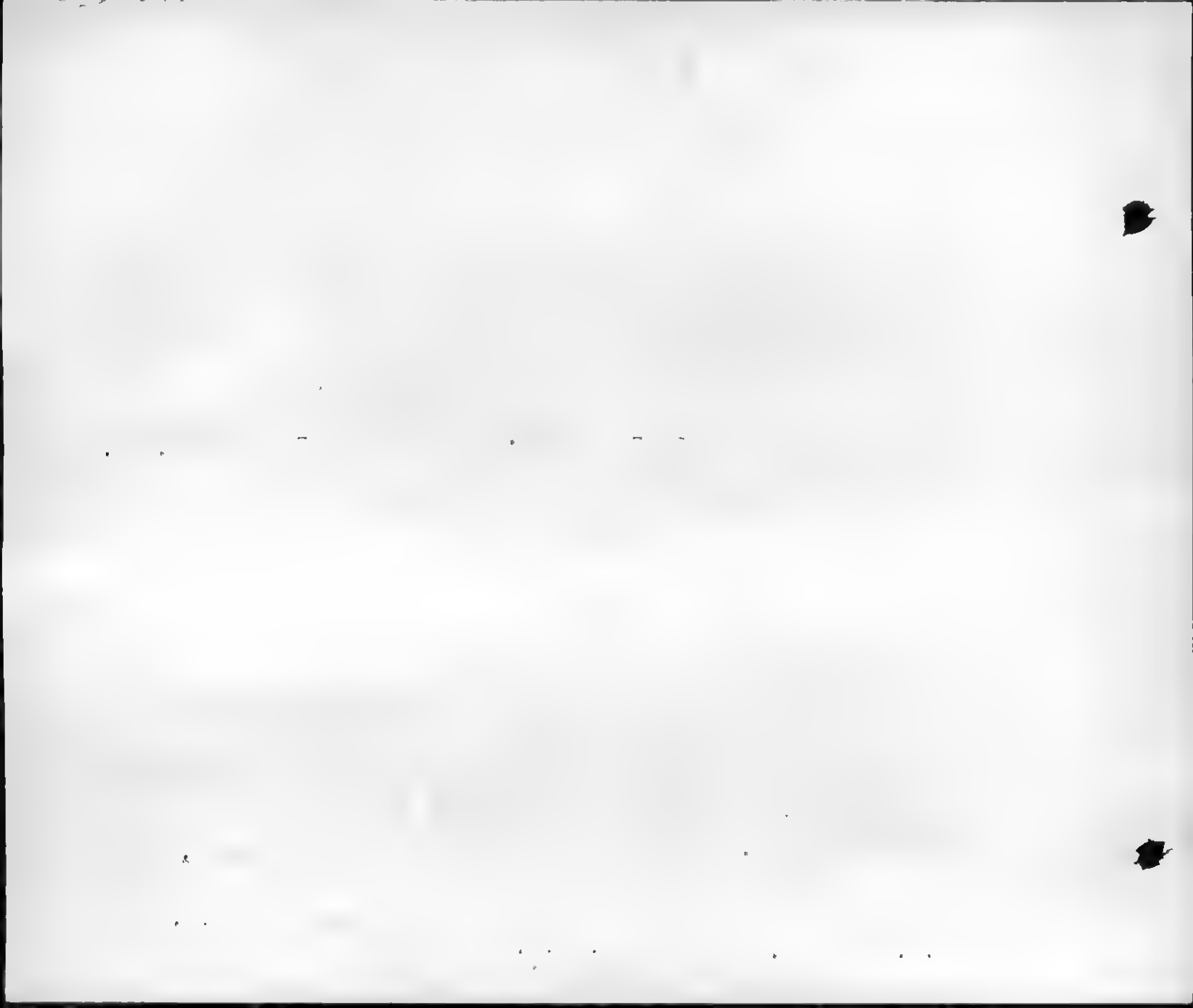


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

<div style="text-align: center;"> 12949 MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
1. PLACE OF DEATH a. COUNTY <i>Prince George's</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>1-1</i>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Greenbelt</i>				c. LENGTH OF STAY IN 1b <i>about 3 mo</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>67 Greenbelt</i>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>3-1 Lakeside Drive</i>				d. STREET ADDRESS <i>1 34 Lakeside Dr.</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Leon's</i> Middle <i>Vasilis</i> Last <i>Vasilis</i>				4. DATE OF DEATH Month <i>Nov</i> Day <i>10</i> Year <i>1960</i>							
5. SEX <i>Male</i>		6. COLOR OR RACE <i>Wh</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>1/7/1894</i>		9. AGE (In years last birthday) <i>66</i> yrs.		IF UNDER 1 YEAR Months <i></i> Days <i></i> Hours <i></i> Min <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Doctors Hospital</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Latvia</i>				11. BIRTHPLACE (State or foreign country) <i>Latvia</i>			
12. CITIZEN OF WHAT COUNTRY? <i>Latvia</i>				13. FATHER'S NAME <i>Andrea Vasilis</i>				14. MOTHER'S MAIDEN NAME <i>Karlina Bromulds</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>				16. SOCIAL SECURITY NO. <i>579-44-8886</i>				17. INFORMANT <i>Mrs. Marta Vasilis-34 Lakeside Drive Greenbelt, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]											
PART I. DEATH WAS CAUSED BY— IMMEDIATE CAUSE (a) <i>Myocardial infarction</i> 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerosis</i> DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Cardiac decompensation</i>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>2-27</i> <i>1960</i> <i>Nov 10</i> , 19 <i>46</i> , that (I) (we) last saw the deceased alive on <i>5:25 AM</i> <i>1946</i> , and that death occurred at <i>5:35 AM</i> , from the causes and on the date stated above.											
22a. SIGNATURE <i>William C. Weintraub</i>				22b. ADDRESS <i>9 E Parkway, Greenbelt, Maryland</i>				22c. PHYSICIAN'S NAME (Type) <i>William C. Weintraub</i>			
23a. BURIAL, CREMATION, REMOVAL. (Specify) <i>Burial</i>				23b. DATE THEREOF <i>11/12/60</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Rock Creek Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Washington, D.C.</i>			
24. FUNERAL DIRECTOR'S SIGNATURE <i>The S.H. Hines Co.</i>				25a. REC'D BY REGISTRAR <i>2901 14th St. N.W.</i>				25b. REGISTRAR'S SIGNATURE <i>DATE NOV 14 '60</i>			



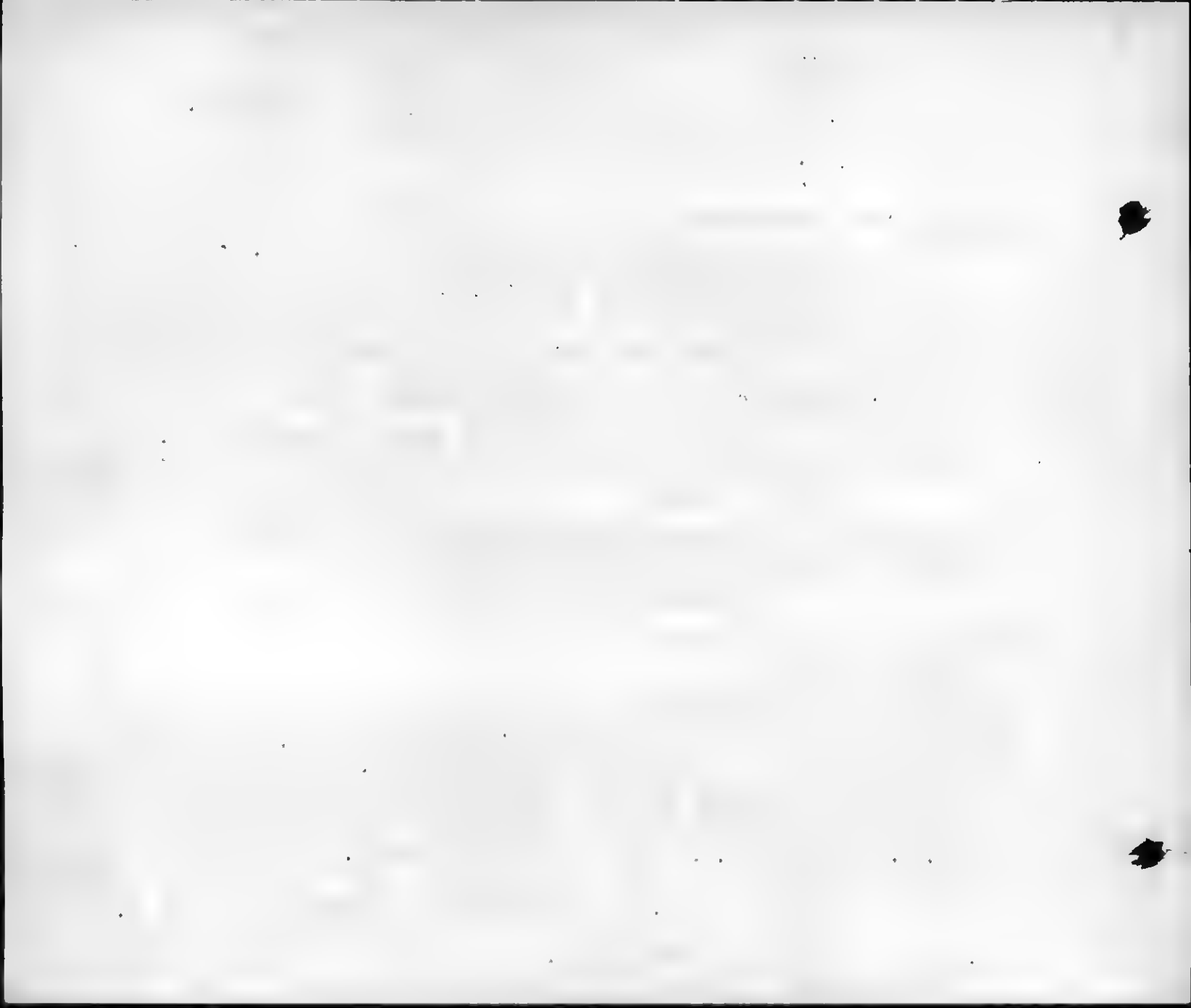
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12965

12945

1 PLACE OF DEATH a. COUNTY Prince George MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 6 Weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Blanche First V Middle Vetter Last		4. DATE OF DEATH Month Nov. Day 28 Year 1960	
5 SEX Female	6. COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 5, 1899
9. AGE (In years last birthday) 61 yrs		10. IF UNDER 1 YEAR Months Days Hours	11. IF UNDER 24 HRS Hours Min
10a. OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Department Store	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME George Reeder		14. MOTHER'S MAIDEN NAME May Butler	
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT Hospital records		Address Cheverly Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Arteriosclerotic Cardiovascular-Renal disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH Months Years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from Nov. 28 , 19 60 , to Nov. 28 , 19 60 , that (I) (we) last saw the deceased alive on Nov. 28 , 19 60 , and that death occurred at 3:35 P.M. , from the causes and on the date stated above.			
22a. SIGNATURE Wm. C. Weintraub		22b. DATE SIGNED Nov. 28 1960	
22c. PHYSICIAN'S NAME (Type) Wm. C. Weintraub ; M.D.		22d. ADDRESS Greenbelt, Md.	
23a. BURIAL, CREMATION OR REMOVAL (Specify) Burial	23b. DATE THEREOF 12/1/60	23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	23d. LOCATION (City, town, or county) (State) Colmar Manor Md.
24 FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		25a. REGISTERED BY REGISTRAR DEC 1 1960	
ADDRESS Hyattsville, Md.		25b. REGISTRAR'S SIGNATURE Arthur E. Hume	

TO HOSPITAL: THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

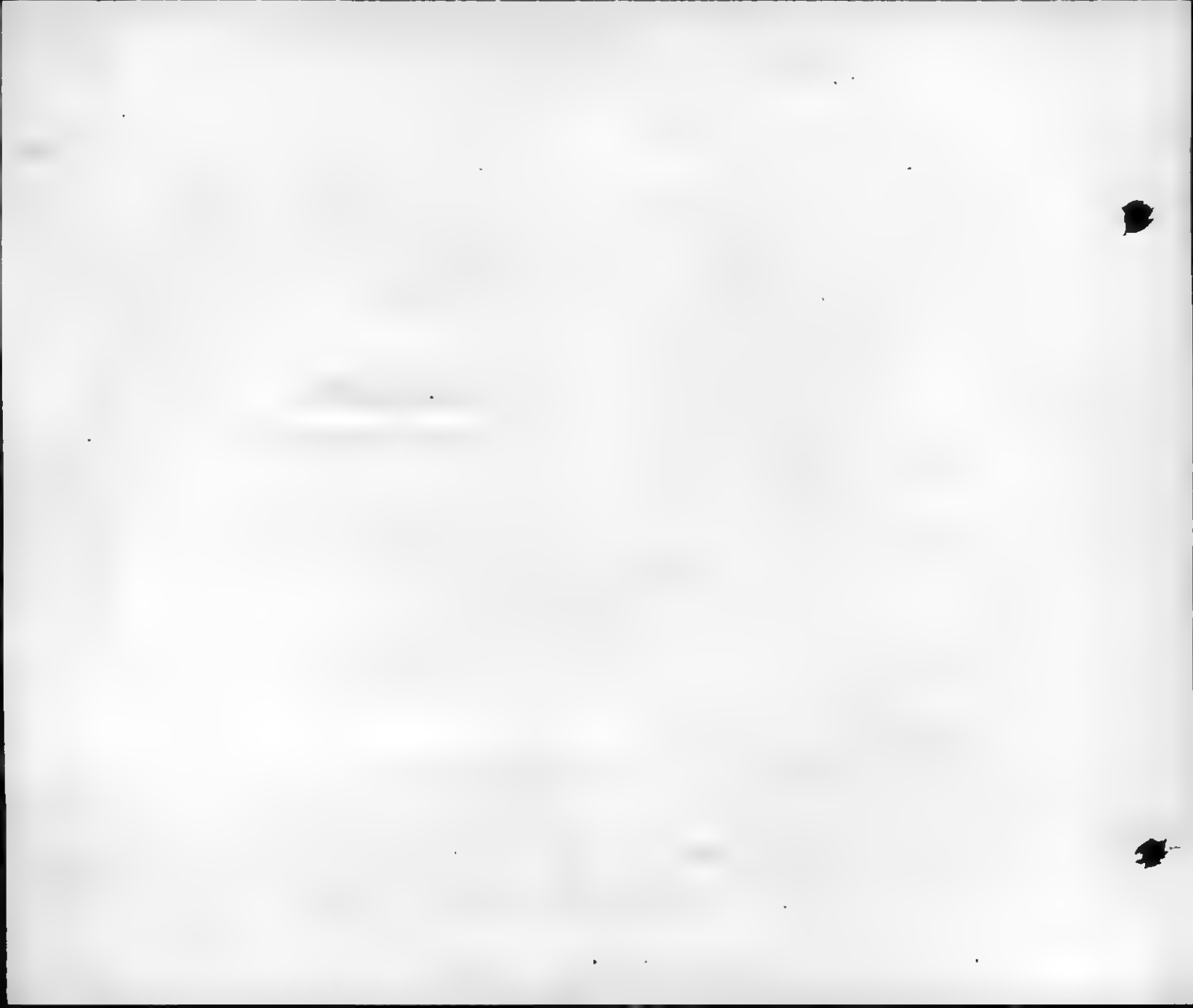
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12944

12964

1 PLACE OF DEATH a COUNTY <u>Prince George</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a STATE <u>Md.</u> b COUNTY <u>Prince George</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c LENGTH OF STAY IN 1b <u>56</u> Lanham	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George General</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>CORA</u> Middle <u>G.</u> Last <u>VAUGHN</u>		4 DATE OF DEATH Month <u>Nov.</u> Day <u>25</u> Year <u>1960</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH <u>July 29 1903</u>
9 AGE (In years last birthday) <u>57</u> yrs		10 IF UNDER 1 YEAR Months <u>5</u> Days <u>7</u> Hours <u>15</u> Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b KIND OF BUSINESS OR INDUSTRY <u>self</u>	
11 BIRTHPLACE (State or foreign country) <u>Va</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>George Whetzel</u>		14 MOTHER'S MAIDEN NAME <u>Emma J. Smith</u>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16 SOCIAL SECURITY NO <u>none</u>	
17 INFORMANT <u>Betty Biggs Murphy Seabrook Acres Md.</u>		Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u>		<u>3 yrs.</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Parkinson's Disease</u>			
(c) <u>Dehydration</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Extensive decubitus ulcers.</u>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour <u>o. m.</u> <u>19</u> p. m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>Oct. 26, 1960</u> to <u>Nov 25, 1960</u> , that (I) (we) last saw the deceased alive on <u>Nov 24, 1960</u> , and that death occurred at <u>9 A</u> M, from the causes and on the date stated above.			
22a SIGNATURE <u>Francis X Carrillo</u>		22b DATE SIGNED	
22c PHYSICIAN'S NAME (Type) <u>Francis X Carrillo</u>		22d ADDRESS <u>1013 Univ. Blvd E Silver Spring Md</u>	
23a BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>Nov 28, 1960</u>	
23c NAME OF CEMETERY OR CREMATORY <u>Bergton Lutheran Cemetery</u>		23d LOCATION (City, town, or county) (State) <u>Bergton Virginia</u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons Hyattsville, Md.</u>		25a REC'D BY REGISTRAR DATE <u>NOV 29 '60</u>	
ADDRESS		25b REGISTRAR'S SIGNATURE <u>William S. Thomas</u>	



Reg. Dist. No. 12966

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE VA. b. COUNTY ARLINGTON ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYATTSVILLE		c. LENGTH OF STAY IN 1b 1 MONTH	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HYATTSVILLE NURSING HOME		d. STREET ADDRESS 2629 Wash. Blvd.	
3. NAME OF DECEASED (Type or print) CLARENCE W. WARD, Sr.		4. DATE OF DEATH Month 11 Day 21 Year 1960	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/17 - 1868
9. AGE (In years last birthday) yrs. 92		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER		10b. KIND OF BUSINESS OR INDUSTRY Builder	
11. BIRTHPLACE (State or foreign country) Augusta, Maine		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Anson Tillson Ward		14. MOTHER'S MAIDEN NAME Mary Robbins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 579-12-7334	
17. INFORMANT Clarence W. Ward, Sr.		Address Hilleah, Fla.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerosis, renal disease 4422X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 12 , 19 60 , to Nov 21 , 19 60 , that I last saw the deceased alive on Nov 21 , 19 60 , and that death occurred at 11:00 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Washington, D.C. DATE SIGNED Nov 28 1960			
ACTUAL SIGNATURE W. H. C. ... M.D. ...			
PHYSICIAN'S NAME (Type) W. H. C. ...			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 11-23-60	
22c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Ives Funeral Home, Inc. C. P. ...		24a. REC'D BY REGISTRAR NOV 28 1960	
ADDRESS Arlington, Va.		24b. REGISTRAR'S SIGNATURE Arthur S. ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. These plates remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO EPIDEMIOLOGICAL MEDICAL EXAMINER: This certificate should be examined within 24 hours after death. If necessary, please excuse the certificate, writing the word "pending" in pencil in item 18. Give §§ages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Licensure or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

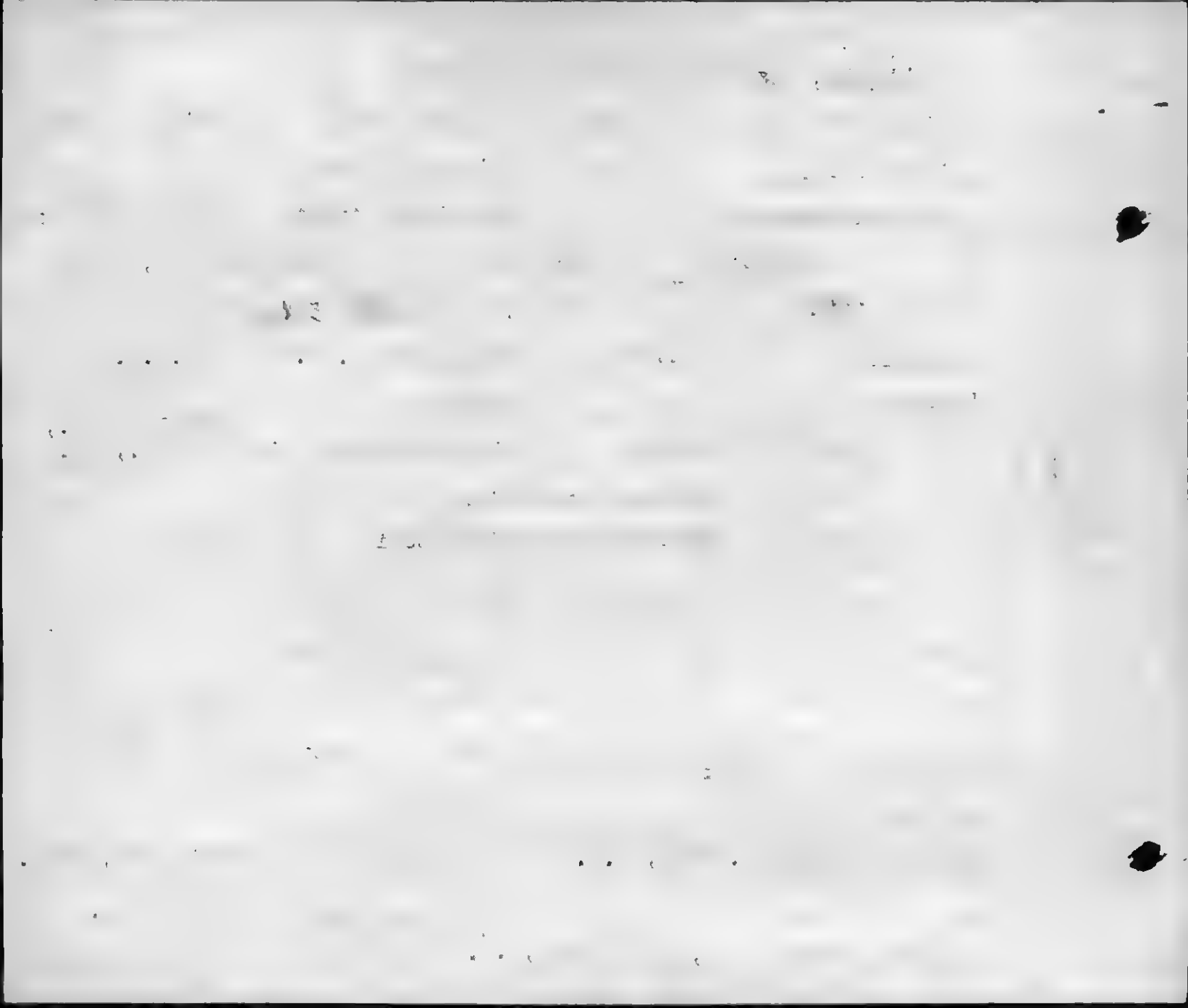
MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12967

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence b. for admission) a. STATE	
Prince Georges		Maryland	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		b. COUNTY	
Highland Park		Prince Georges	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS	
1206 70th Street		1206 70th Street	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
HENRIETTA WASHINGTON		November 22, 1960	
5. SEX		8. DATE OF BIRTH	
Female		Dec 26, 1904	
16. COLOR OR RACE		9. AGE (In years, last birthday)	
Negro		65 1/2 yrs	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		10. BIRTHPLACE (State or foreign country)	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Wilmington N. C.	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
U.S.A.		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Unknown		Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17. INFORMANT	
No		William Washington	
16. SOCIAL SECURITY NO.		Address	
None		1206 70th St., Highland Pk., Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Toxemia Exhaustion	
19.2 DUE TO		Generalized Carcinomatosis	
Conditions, if any, which gave rise to immediate cause (b)			
20. DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m., p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
JAMES I. BOYD, M.D.		DATE SIGNED	
November 22, 1960			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Burial		11-26-60	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country) (State)	
Harmony Memorial		Seat Pleasant, Md.	
23. FUNERAL DIRECTOR		24b. REGISTRAR'S SIGNATURE	
ROLLINS FUNERAL HOME, Washington, D.C.		C. L. R. R. R.	



12996

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12968

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>M.D.</u> b. COUNTY <u>CHARLES</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BRANDYWINE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LA PLATA</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>BRANDYWINE-WALDORF CLINIC</u>				d. STREET ADDRESS <u>X 2</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES ALEXANDER WHEELER</u>				4. DATE OF DEATH Month Day Year <u>Nov 5 1960</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 12, 1912</u>	9. AGE (In years last birthday) <u>48</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HIGHWAY MAINTENANCE STATE ROAD</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ARTHUR JAMES WHEELER</u>				14. MOTHER'S MAIDEN NAME <u>ESTELLE CHASE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <u>NO</u>				16. SOCIAL SECURITY NO. <u>220-16-7865</u>		17. INFORMANT Address <u>MRS. SARAH WHEELER, LA PLATA, MD.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Carcinomatosis</u> DUE TO (c) <u>Carcinoma of Stomach</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7-18</u> 19 <u>60</u> , to <u>11-5</u> 19 <u>60</u> that (I) (we) last saw the deceased alive on <u>11-5</u> 19 <u>60</u> , and that death occurred at <u>2</u> P.M., from the causes and on the date stated above.							
22a. SIGNATURE <u>Richard H. Dobson</u> M.D.				22b. ADDRESS <u>La Plata, Md.</u>			
22c. PHYSICIAN'S NAME (Type) <u>Richard H. Dobson</u>				22d. ADDRESS <u>La Plata, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>11-9-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>SACRED HEART</u>		23d. LOCATED ON (City, town, or county) (State) <u>LA PLATA, M.D.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>THE HUNT FUNERAL HOME, WALDORF, M.D.</u>				25a. REC'D BY REGISTRAR DATE <u>NOV 14 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Charles S. Kline</u>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1296.

12964

1. PLACE OF DEATH
a. COUNTY **Prince George** MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Riverdale** D.O.A.
c. LENGTH OF STAY IN b. **D.O.A.**
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) **Leland Memorial Hospital**

2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)
a. STATE **Maryland** b. COUNTY **Baltimore**
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Baltimore**
d. STREET ADDRESS **1615 Park Ave.,**

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) **Katherine Mae Whistler**
First Middle Last
4. DATE OF DEATH **November 11, 1960** Month Day Year
5. SEX **Female** 6. COLOR OR RACE **White** 7. MARRIED ☐ NEVER MARRIED ☐ 8. DATE OF BIRTH **Nov. 20, 1892** 9. AGE (In years last birthday) **67** yrs. 10. F UNDER 1 YEAR ☐ 11. F UNDER 24 HRS. ☐
Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Practical Nurse** 10b. KIND OF BUSINESS OR INDUSTRY **Nursing** 11. BIRTHPLACE (State or foreign country) **Virginia** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13. FATHER'S NAME **Adam Brown Croushorn** 14. MOTHER'S MAIDEN NAME **Mollie Colner**

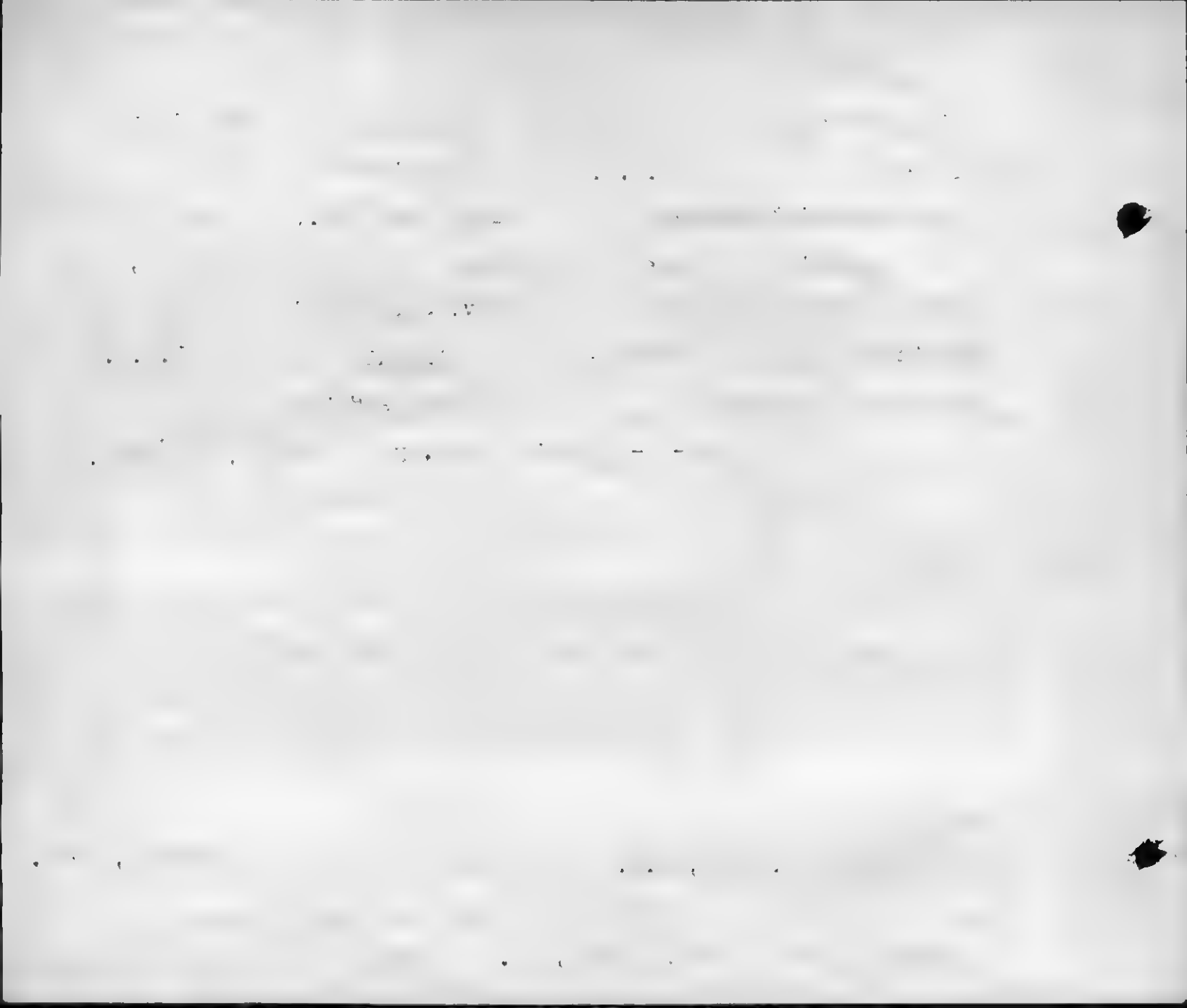
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **no** 16. SOCIAL SECURITY NO. **227-10-3571** 17. INFORMANT **Mildred B. Lynn** Address **407 Star Route, Laurel, Maryland.**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) **Hemorrhage and Shock**
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) **Fracture of the base of the skull**
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY () OR CONTRIBUTING () CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) **Occupant of an auto that went out of control**
20c. TIME OF INJURY Month, Day, Year **Nov. 11 1960** 20d. INJURY OCCURRED While () Not While () at work () at work () 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) **At 198 + Simpson Dr. Laurel, Md.** 20f. (City or town) **Laurel** (County) **Ind** (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE **James I. Boyd** CHIEF MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type) **JAMES I. BOYD, M.D.** ASS. STANT MEDICAL EXAMINER ☐
22a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 22b. DATE THEREOF **Nov 14 1960** 22c. NAME OF CEMETERY OR CREMATORY **National Memorial** 22d. LOCATION (City, town, or country) (State) **Rolls Church, Virginia**
23. FUNERAL DIRECTOR **Donaldson** ADDRESS **Donaldson Funeral Home, Laurel, Md.** 24a. REC'D BY REGISTRAR **NOV 15 '60** 24b. REGISTRAR'S SIGNATURE **Arthur S. Kraus**



12946

12970

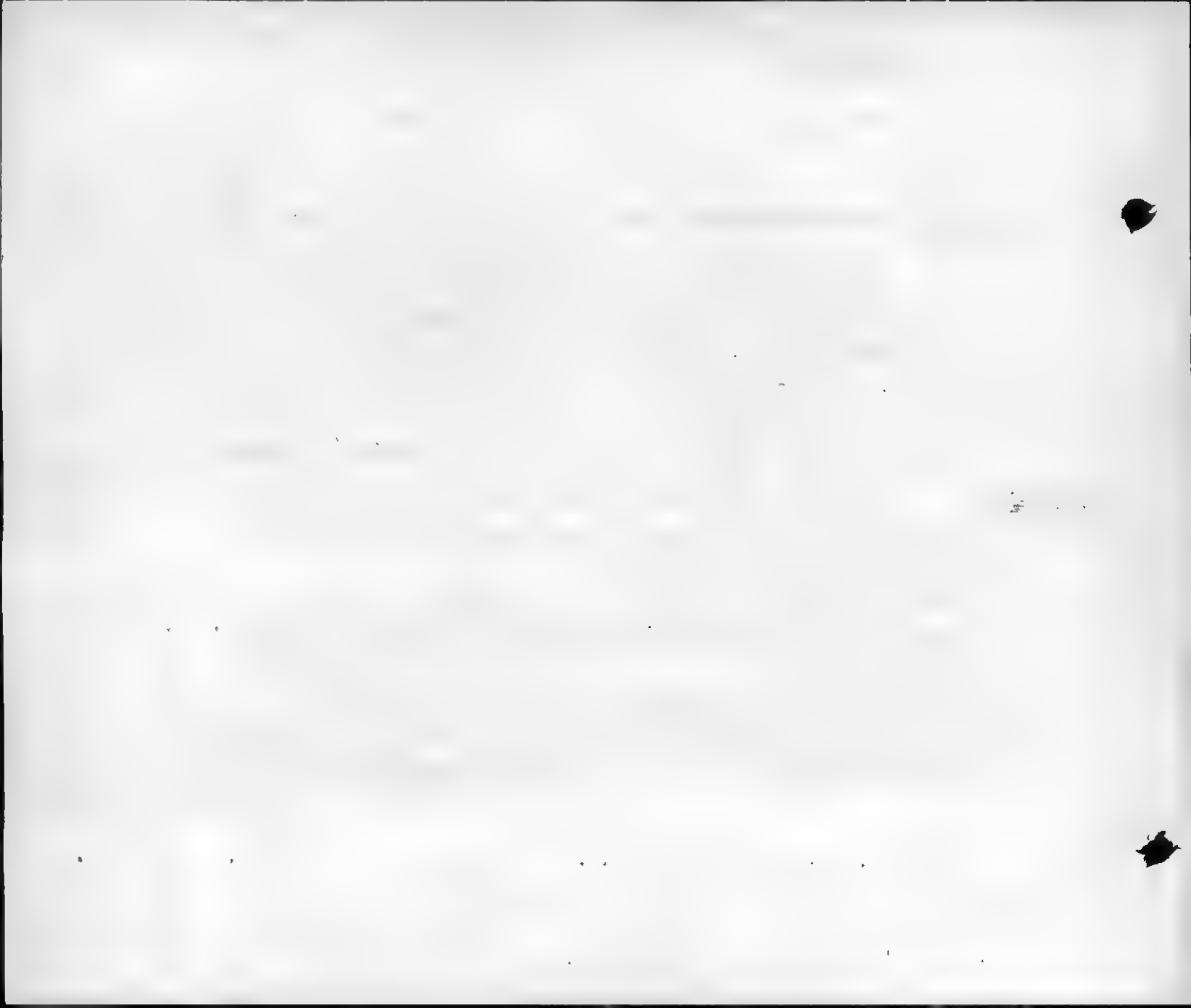
1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Prince Georges E MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 6 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. STREET ADDRESS 4011 Longfellow Street	
3. NAME OF DECEASED (Type or print) First Middle Last Walter C Whitcraft		4. DATE OF DEATH Month Day Year Nov 13 1960	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 20 Feb 1892
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pressman		10b. KIND OF BUSINESS OR INDUSTRY Govt. Printing Off.	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Walter C. Whitcraft		14. MOTHER'S MAIDEN NAME Doretta Doremus	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO WW 1	
17. INFORMANT Edith H. Whitcraft (Wife)		Address Same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock and Toxemia DUE TO (b) Generalized Peritonitis DUE TO (c) Ruptured Duodenal Ulcer		INTERVAL BETWEEN ONSET AND DEATH 48 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Multiple old myocardial infarcts secondary to Coronary Arterioscl. HT. IS		19. WAS AUTOPSY PERFORMED? NO	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from Nov. 12 1960 to Nov. 13 1960 that (I) (we) last saw the deceased alive on Nov 12 1960 and that death occurred at 555AM from the causes and on the date stated above.			
22a. SIGNATURE Ronald S Fleischer M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. Ronald S Fleischer M.D.		22d. ADDRESS 5422 Queens Chapel Rd. Hyattsville., Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/16/60	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington, Va.	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.	
25a. REC'D BY REGISTRAR NOV 17 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Thoms	

TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



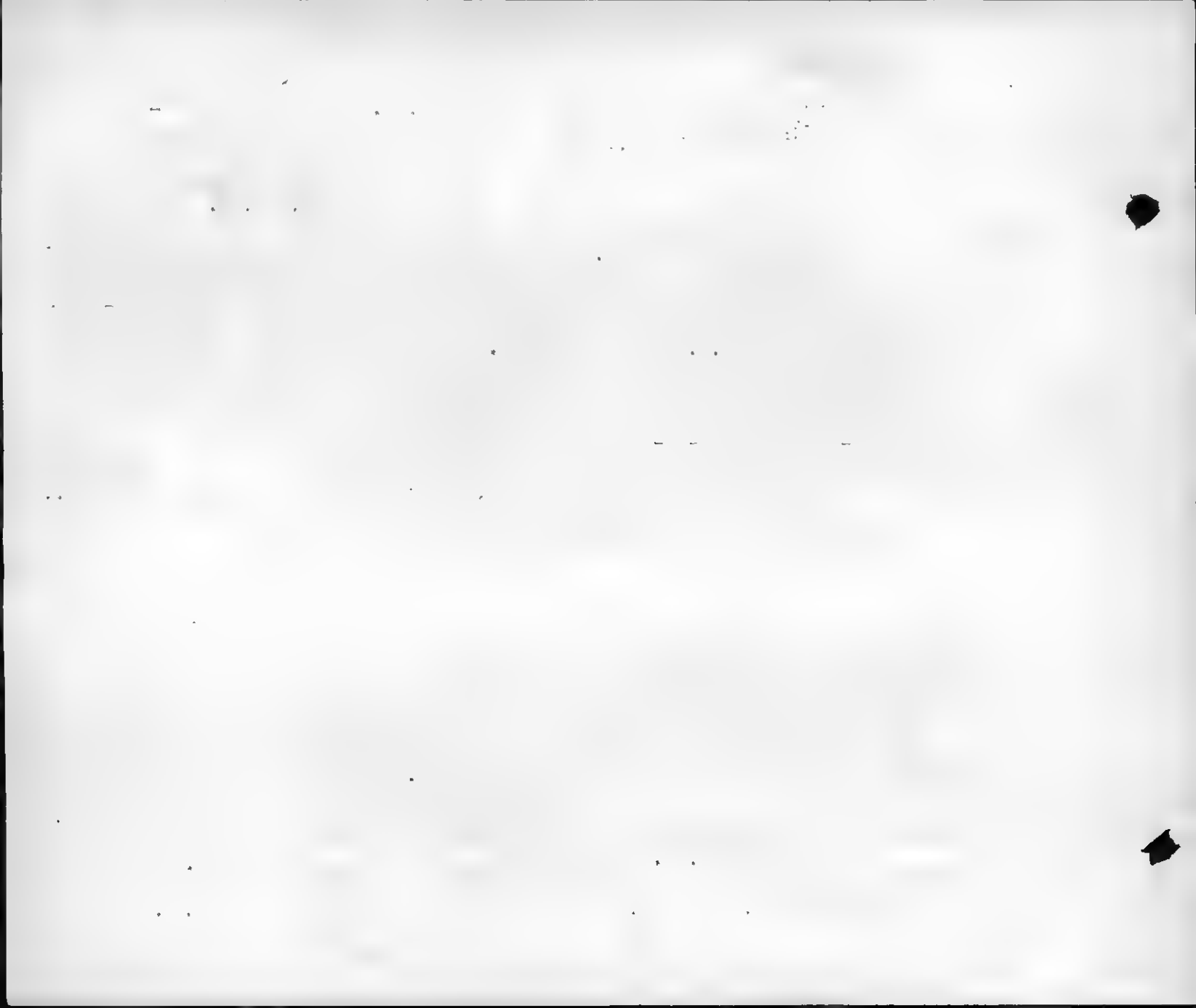
TO HOSPITAL OR ATTENDING PHYSICIAN: The low require that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 11-59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
12997
CERTIFICATE OF DEATH

12971

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE D. C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital		d. STREET ADDRESS 1110 Eye St., N. E.	
3. NAME OF DECEASED (Type or print) First William Middle W. Last White		4. DATE OF DEATH Month 11 Day 21 Year 19 60	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/10/1900
9. AGE (In years last birthday) 60 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY D.C. Sanitation Dept.	
11. BIRTHPLACE (State or foreign country) Elmo, Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas White		14. MOTHER'S MAIDEN NAME Jennie Brown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -		16. SOCIAL SECURITY NO 577-36-9082	
17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary tuberculosis, far advanced 2X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 yrs.,	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of left pleura, primary site undetermined; left thoracotomy, 10/28/60; cor pulmonale		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/7/1960 to 11/21/1960, that (I) (we) last saw the deceased alive on 11/21/1960, and that death occurred at P. M. from the causes and on the date stated above.			
22a. SIGNATURE Moe Weiss, M. D.		22b. DATE SIGNED 11/21/60	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M. D.		22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11.26.60	
23c. NAME OF CEMETERY WOODLAWN		23d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert H. McKinnis		25a. REC'D BY REGISTRAR DATE NOV 28 '60	
ADDRESS 1920-9th St. W.		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	



12948

CERTIFICATE OF DEATH

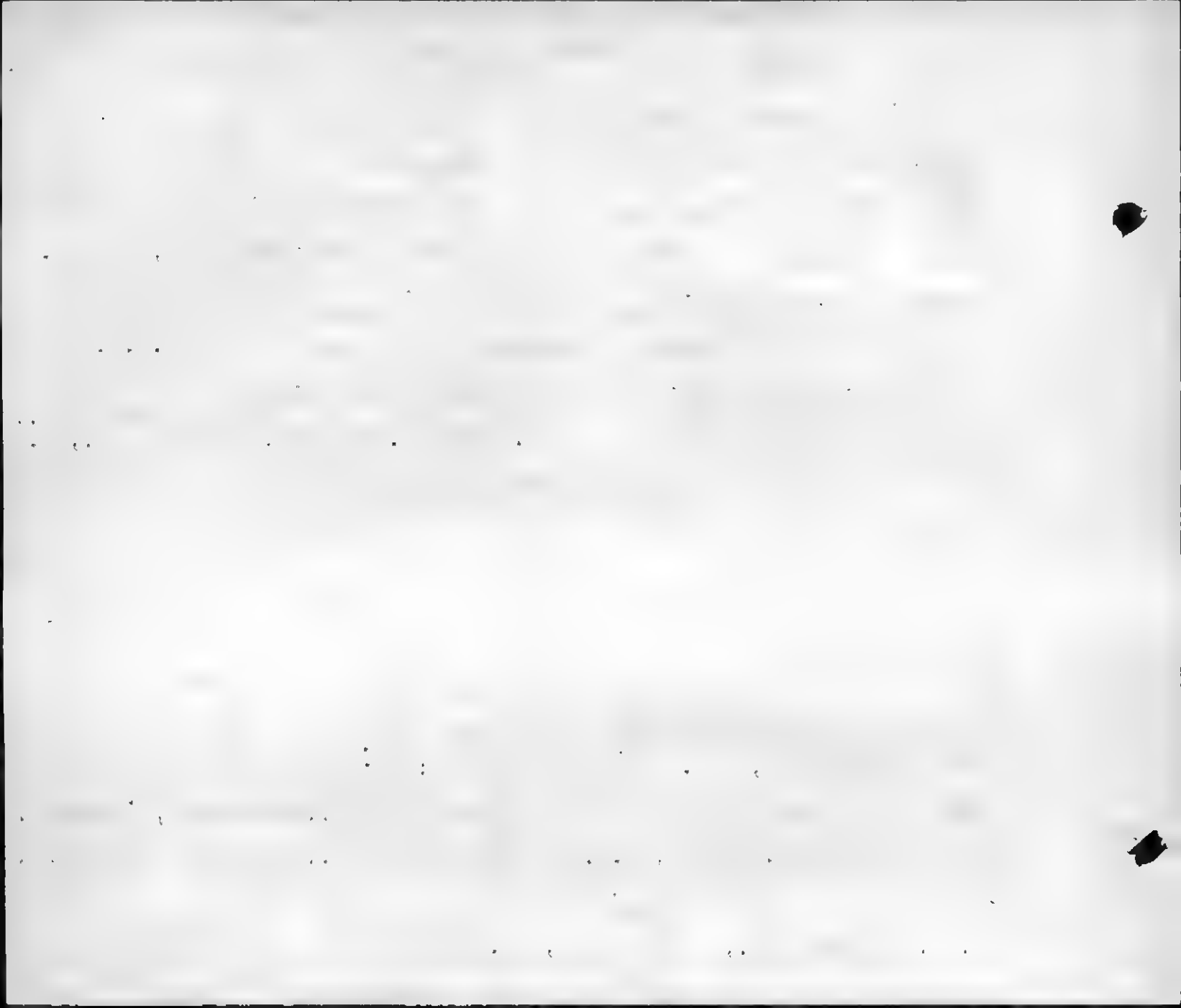
Reg. Dist. No.

12972

1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edmonston		c. LENGTH OF STAY IN 1b 20 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4924 Lafayette Place		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last DAISY MARY WIGHINGTON		4. DATE OF DEATH Month Day Year November 18, 1960.	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 27 1889
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CURRENCY TRIMMER		10b. KIND OF BUSINESS OR INDUSTRY Bureau of Engraving	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES AUBREY Dove		14. MOTHER'S MAIDEN NAME Margaret Mary Birch	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO None	
17. INFORMANT Mrs. Gloria A. Yarmola,		Address 9741 51st Ave., College Pk., Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 20 , 19 57 , to Nov. 18 , 19 60 , that I last saw the deceased alive on November 18 , 19 60 , and that death occurred at 10:40 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Md. 5701 85th Ave., Carrollton, Md. DATE SIGNED 11/18/60.			
ACTUAL SIGNATURE William D. Rosson M.D.		PHYSICIAN'S NAME (Type) WILLIAM D. ROSSON, M.D. 5701 85th Ave., Carrollton, Maryland.	
22a. BURIAL CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF Nov. 22, 1960	22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL	22d. LOCATION (City, town or county) (State) ARLINGTON, VIRGINIA
23. FUNERAL DIRECTOR'S SIGNATURE W. W. CHAMBERS CO.,		ADDRESS Riverdale, Md.	
24a. REC'D BY REGISTRAR DATE NOV 23 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12998

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12973

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S b. STATE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE DISTRICT OF COLUMBIA b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) CAMP SPRINGS				c. LENGTH OF STAY IN 1b 1 DAY			
c. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) WASHINGTON 20, D.C.				d. STREET ADDRESS 1438 ALABAMA AVE. S.E.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSPITAL ANDREWS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last QUENTIN DERMOIT Womack				4. DATE OF DEATH Month Day Year November 4 1960			
5. SEX Male		6. COLOR OR RACE Neg		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2 NOV 60	
9. AGE (In years last birthday) 1		IF UNDER 1 YEAR Months Days 1 7		IF UNDER 24 HRS Hours Min 7			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NA				10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME WARREN Q Womack				14. MOTHER'S MAIDEN NAME MURPHY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NA				16. SOCIAL SECURITY NO. NA		17. INFORMANT WARREN Q WOMACK (FATHER)	
				Address SAME AS ITEM 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PREMATURITY 776X DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
INTERVAL BETWEEN ONSET AND DEATH 31 HOURS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov 2 , 19 60 , to Nov 4 , 19 60 that (I) last saw the deceased alive on Nov 4 , 19 60 , and that death occurred at 1:00 AM, from the causes and on the date stated above.							
22a. SIGNATURE John R. Delahanty M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED Nov. 4, 1960	
22c. PHYSICIAN'S NAME (Type) JOHN R DELAHANTY, CAPT USAF (MC)				22d. ADDRESS USAF HOSP ANDREWS, ANDREWS AFB, WASH 25,			
23a. BURIAL CREMATION REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11-9-60		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL		23d. LOCATION (City, town, or county) (State) ARLINGTON VA.	
24. FUNERAL DIRECTOR'S SIGNATURE B.F. TAYLOR				ADDRESS 909 6TH ST, N.W. D.C.		25a. REC'D BY REGISTRAR DATE NOV 9 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

Page 4
TO HOSPITAL FOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12894

CERTIFICATE OF DEATH

Reg. Dist. No. 12974

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>P. Geo</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>MD</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Belle Harbor Home</i>		d. STREET ADDRESS <i>11807 Owens Rd S.E.</i>	
3. NAME OF DECEASED (Type or print) First <i>DAVID</i> Middle <i>AHMAN</i> Last <i>WOODCOCK</i>		4. DATE OF DEATH Month <i>Nov</i> Day <i>11</i> Year <i>1960</i>	
5. SEX <i>M</i>	6. COLOR OF RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept 20 - 60</i>
9. AGE (In years last birthday) yrs. <i>1</i> Days <i>22</i>		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Washington DC</i>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Floyd B Woodcock</i>		14. MOTHER'S MAIDEN NAME <i>Mary M^e Grath</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <input type="checkbox"/> If yes, give war or dates of service		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>325.4 Congenital heart disease (acute cardiac collapse)</i> DUE TO (b) <i>Mononucleosis</i> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH <i>1 hour</i> <i>birth on</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Sept 24</i> , 19 <i>60</i> , to <i>11/11</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>11/11</i> , 19 <i>60</i> , and that death occurred at <i>10:20</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Thomas A. Christensen</i>		M.D. <i>6905 Belle Blvd</i> DATE SIGNED <i>11/11/60</i>	
PHYSICIAN'S NAME (Type) <i>THOMAS A. CHRISTENSEN College Park Maryland</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<i>Cremation</i>	<i>Nov 12-60</i>	<i>Cedar Hill</i>	<i>Smithland, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
<i>SIMMONS BROS</i>		<i>1601 G 000 HOPE RD. SE. N.W. DC</i>	<i>Arthur S. Kraus</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death.

CERTIFICATE OF DEATH

1914

NAME

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE

INTERMEDIATE CAUSE

UNDERLYING CAUSE

PERIOD OF ILLNESS

PERIOD OF INCUBATION

PERIOD OF LATENCY

PERIOD OF REMISSION

PERIOD OF AGGRAVATION

PERIOD OF RECOVERY

PERIOD OF DEATH

PERIOD OF BURIAL

PERIOD OF CREMATION

PERIOD OF INTERMENT

PERIOD OF EXHUMATION

PERIOD OF REINTERMENT

PERIOD OF REINTERMENT

PERIOD OF REINTERMENT

PERIOD OF REINTERMENT

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PERIOD OF REINTERMENT

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12975

12999

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY (DISTRICT OF COLUMBIA) P.G.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON			
c. LENGTH OF STAY IN 1b 40 MIN				d. STREET ADDRESS 3712 WELTHAM ST SE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSP ANDREWS, WASH 25 DC				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First NELSON Middle THOMAS Last WRIGHT		4. DATE OF DEATH		Month NOVEMBER Day 8 Year 19 60	
5. SEX MALE	6. COLOR OR RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 11, 1883	9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET ARMY 1ST LT			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) MASSACHUSETTS	12. CITIZEN OF WHAT COUNTRY? UNITED STATES		
13. FATHER'S NAME EDWARD A. WRIGHT			14. MOTHER'S MAIDEN NAME MARGURITE CASSIDY				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 1916-19 42-45		17. INFORMANT EDWARD N WRIGHT (SON)		Address SAME AS ITEM #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]						INTERVAL BETWEEN ONSET AND DEATH 12 HOURS	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RUPTURED ABDOMINAL ANEURYSM							
451X DUE TO							
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost.						(b) DUE TO	
						(c) DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 0130 8 NOV 1960 to 0210 NOV 1960 , that (I) (we) last saw the deceased alive on 8 NOV 1960 , and that death occurred at 8:28 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Andrew W. Butchko				22b. DATE SIGNED 8 NOV 60		22c. PHYSICIAN'S NAME (Type) ANDREW W BUTCHKO CAPT USAF (MC)	
22d. ADDRESS USAF HOSP ANDREWS, ANDREWS AFB, WASH 25, DC				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. DATE 8 NOV 60	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11-10-60		23c. NAME OF CEMETERY OR CREMATORY PLYMOUTH MASS.		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE RINALDI FUNERAL HOME, INC. 816 H ST. N.E.				25a. REC'D BY REGISTRAR NOV 10 '60		25b. REGISTRAR'S SIGNATURE Charles E. Kiana	

MEDICAL CERTIFICATION

10000

STATE OF NEW YORK
IN SENATE
January 10, 1900

10000

REPORT

OF THE

COMMISSIONERS OF THE LAND OFFICE

IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE

AT ITS SESSION ON JANUARY 10, 1899

ALBANY: J. B. LIPPINCOTT & CO., PRINTERS, 1899.

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